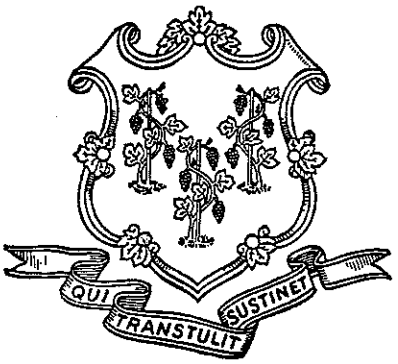
HEALTH CARE COST CONTAINMENT IN CONNECTICUT

Connecticut

General Assembly



LEGISLATIVE
PROGRAM REVIEW
AND
INVESTIGATIONS
COMMITTEE

FEBRUARY 1994

CONNECTICUT GENERAL ASSEMBLY
LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

The Legislative Program Review and Investigations Committee is a joint, bipartisan, statutory committee of the Connecticut General Assembly. It was established in 1972 to evaluate the efficiency, effectiveness, and statutory compliance of selected state agencies and programs, recommending remedies where needed. In 1975, the General Assembly expanded the committee's function to include investigations, and during the 1977 session added responsibility for "sunset" (automatic program termination) performance reviews. The committee was given authority to raise and report bills in 1985.

The program review committee is composed of 12 members. The president pro tempore of the senate, the senate minority leader, the speaker of the house, and the house minority leader each appoint three members.

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HEALTH CARE COST CONTAINMENT IN CONNECTICUT

FINAL REPORT

FEBRUARY, 1994

LEGISLATIVE PROGRAM REVIEW AND INVESTIGATIONS COMMITTEE

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EXECUTIVE SUMMARY
HEALTH CARE COST CONTAINMENT IN CONNECTICUT

The goal of the Legislative Program Review and Investigations Committee's study was to create a regulatory environment that encourages cooperative efforts for controlling costs while setting boundaries for an emerging competitive health care market. The committee's approach was to produce health care reforms that build upon Connecticut's existing health care system. The committee undertook a comprehensive examination of health care finance and delivery in the state by profiling the marketplace and examining system-wide trends.

The committee also conducted a performance evaluation of the Commission on Hospitals and Health Care and examined the history of cost containment in Connecticut, the budget and rate review process, certificate of need responsibilities, and health care planning. The committee's report details the role of consumers, health insurers, hospitals, health care providers, managed care arrangements, health plans, and employer benefit programs, as well as cost information and public opinion on the operation of the system.

As part of the study, over 120 individuals active in Connecticut's health care delivery and finance -- doctors, hospital administrators and staff, large and small employers, insurers, HMO representatives, health care researchers, third-party administrators, health benefit administrators and agents, unions, and consultants -- were interviewed. Numerous studies, articles, legislation, and books on health care were reviewed. Detailed information on other state and federal health care reform proposals were evaluated.

The committee found a health care system that has been experiencing great change over the last two years. The market has begun to shift from a fee-for-service system to emerging networks of doctors linked to organized payment systems and programs of utilization controls. The shift in the market has generally been in response to cost containment efforts by the private sector.

In the 1970s, cost controls efforts centered upon employers moving to self-funded arrangements designed to limit exposure to administrative costs and health risk by insuring only their own workers. However, administrative costs effect only a small percentage of the costs and health risks in small groups can be expensive depending upon the population's demographics.

The 1980s witnessed efforts to control the total medical costs by controlling the price charged for services. The Commission on Hospitals and Health care has attempted to control costs through a number of different regulatory methodologies including hospital rate control and budget approval. Fee-for-service indemnity plans also tried to limit the amount paid pay for a health care services. Controlling for price increases, while somewhat significant, still only accounts for a small portion of total medical costs.

In the 1990s, the market has sought to contain the most important factor driving medical costs; the utilization of services. Committee research has found that managing the utilization of services has become the primary focus of private health care companies and state governments seeking to contain costs.

The keys to containing health care costs and maintaining high quality are: to provide adequate information on health care outcomes; to control the utilization of services; and to reduce price increases for health care services. These goals must be built into the design of any new health care delivery system. The current delivery system has only begun to address these areas.

Health services in Connecticut have historically been provided by a loosely structured delivery system organized at the community level and financed by a variety of sources. The delivery of services has been largely provided by individual practitioners or small medical groups and paid for on a fee-for-service basis. Institutional health care is offered by numerous facilities, many of them non-profits entities, located throughout Connecticut and in bordering states.

However, there is no single statewide system of purchasing health insurance. Rather, individuals and families receive coverage through an extensive variety of employer- and government-sponsored benefit plans. These private and public plans differ in benefits covered, sources of funding, and payments to medical care providers.

Competition. The health care market in Connecticut has the potential to become very competitive. The following five indicators have led to this conclusion. First, the state has excess hospital capacity, in terms of beds; second, a geographically dispersed hospital network with a high number of community hospitals per square mile; third, the population to physician ratio is one of the highest in the nation in all categories except general/family practitioners is one ; fourth, a large number of insurers offering an array of health plans, including HMOs, with no single insurer, except medicare, having more than 20 percent of the market share; and finally, Connecticut has the second highest insured population in the nation. In addition, barriers to entry to the health care market are not limited.

Though the market has gradually begun to shift from a fee-for-service reimbursement system to capitated managed health care plans, there has not been a corresponding shift in the regulatory structure. The current market direction towards more competitive health systems is at odds with an antiquated hospital cost containment regulatory structure. To achieve health care reform, it is necessary to design a government organization that can shape and guide a dynamic, competitive, health care finance and delivery system.

Given these findings, Connecticut is well positioned to move to a competitive health care system. The demand side of the market into large purchasing groups that can adequately share health risk. The state needs to restructure the regulatory environment by creating the necessary

information base to support competition in the health care sector, and encouraging the development of standardized health plans than can be compared by consumers.

Regulatory structure. The regulatory structure covering the marketplace is as varied and fragmented as the delivery system. Four major state agencies have jurisdiction over health care services: 1) the Department of Insurance; 2) the Department of Public Health and Addiction Services; 3) the Commission on Hospitals and Health Care; and 4) the Department of Social Services. These agencies have different responsibilities related to each area of the market. The insurance department is largely responsible for assuring the financial solvency of companies offering health insurance products and approving health plans. The health department licenses many health providers and institutions and provides health planning for the delivery system. The Commission on Hospitals and Health Care has been responsible for containing costs by regulating the hospital sector through budget and rate review and approval of capital expenditures. The fourth agency, the Department of Social Services, is responsible for providing access to health care for poor and disabled citizens.

The Legislative Program Review and Investigations Committee's study presents a comprehensive plan to contain costs and reform the health care in Connecticut. The recommendations are intended to encourage the development of a competitive health care market that is monitored by a well-designed state agency with clearly defined functions. The report recommends eliminating hospital budget and rate regulation and the Commission on Hospitals and Health Care. In its place it proposes to:

- Create an **Agency for Health Systems** that is designed to establish the boundaries within which a competitive market shall operate. A single state agency will take the state's fragmented approach to health care and focus on the four major pieces of health care management: health systems planning; financing and developing health plans; cost containment; and access.

- Promote the creation of **certified health plans** that will require the health provider side of the market to organize into cost-effective and efficient integrated delivery systems available to consumers.

  Certified health plans will be offered on a community rated basis to large pools of insured individuals and are the key ingredient to cost containment; an important function that must be part of any reform proposal.

- Establish the **Connecticut Health Data Institute** which will be responsible for collecting information on how the health care system operates. The data institute is designed as a cooperative effort among the participants in the health care market.

For a competitive market to function properly adequate information must be available. The purpose of the institute is to provide this information for competitive, not regulatory, purposes. It must foster collaborative efforts in data collection if it is to be successful.

- Encourage the growth of **competitive health plan purchasing cooperatives.** The purchase of health insurance by large groups is widely recognized as one of the most effective cost containment measures that can be undertaken. Organizing the consumer side of the market is as important as organizing the provider side if a truly competitive market is to be attained. The proposed competitive purchasing cooperatives accomplish the goal of providing small businesses access to the same market as very large companies.

RECOMMENDATIONS

The Legislative Program Review and Investigation Committee recommends that the regulation of hospital budgets and rates be ended. It is further recommended that all payers be allowed to negotiate with hospitals on the delivery of services to their members. It is further recommended that all hospital costs, both inpatient and outpatient services, be monitored with respect to revenues, expenses, and utilization, and the information shall be submitted to the Connecticut Health Care Data Institute. The certificate-of-need program shall be modified based upon recommendations found in this report.

The Agency for Health Systems

The Legislative Program Review and Investigation Committee recommends creation of the *Agency for Health Systems*. The agency shall be governed by a health policy council composed of the commissioner of insurance, the commissioner of Public Health and Addictive Services, or their designees, and the commissioner of the Agency for Health Systems. The commissioner of the agency shall be appointed by the governor and is the administrative head. The health policy council shall be responsible for establishing health systems policy, adopting regulations, and certifying and licensing entities under the purview of the agency. The health policy council may designate advisory councils as it deems necessary for the implementation of health policy.

The purpose of the new state entity, the Agency for Health Systems, is to provide oversight in two areas that are currently separate and detached: the regulation of health insurance plans and the provision of health care services. The principal responsibility of this new agency will be to coordinate the interests of insurers, providers, and consumers of health care.

Specifically the agency will be responsible for:

- **regulating major capital expenditures and the acquisition of technologically advanced equipment through certificate of need;**
- **certifying all health plans sold in Connecticut;**
- **licensing competitive health plan purchasing cooperatives;**
- **developing a state health plan, in conjunction with the Department of Public Health and Addictive Services;**
- **data collection and information;**
- **establishing incentives for the development of managed care health networks;**
- **obtaining information on contractual arrangements between providers and certified health plans;**
- **tracking health care costs, including hospital revenues and expenditures;**
- **administering the uncompensated care pool;**
- **expanding health care access through insurance for all residents of the state; and**
- **promoting cooperative agreements among hospitals.**

The agency will be composed of four bureaus: Health Planning and Certificate of Need Regulation; Health Care Systems Regulation; Health Care Access and Uncompensated Care; and Health Care Data Collection and Information. These four bureaus shall be responsible for monitoring and regulating a competitive health care market in Connecticut. (This agency would replace the Commission on Hospitals and Health Care, take over the planning functions from the Department of Public Health and Addiction Services, and provide for the regulation of certified health insurance policies.)

Bureau of Health Care Systems Regulation. **This new bureau shall be responsible for regulating all aspects of health care insurance (with the exception of financial solvency) and delivery systems. The agency shall be responsible for carrying out the following statutory provisions:**

- **set standards for and certify health plans to be offered to purchasing cooperatives;**
- **license managed care and utilization review companies and third-party health insurance administrators;**
- **assist in the organization of and license competitive health plan purchasing cooperatives; and**
- **require all contracts between providers, insurers and consumers be filed with the agency.**

Certified health plans. **The agency will be responsible for encouraging the formation of integrated health networks -- systems of health care providers and facilities responsible for managing the care of enrollees -- as certified health plans. The agency shall be responsible for setting standards for certified health plans. Certified health plans shall be**

defined as those plans containing the following basic elements: a contracted network of providers; a managed care and utilization review program; capitated rates to purchasers; a quality assurance program; and the financial and administrative capability to provide reimbursement for services used by enrollees as defined by the plan. Certified health plans shall also conform to the statutory provisions of Part I (Health Care Centers) of Chapter 698a and Part III (Group Health Insurance) and IV (Comprehensive Health Care Plans) of Chapter 700c of the Connecticut General Statutes. In addition to the current statutory provisions, certified health plans shall be standardized to prevent insurers from engaging in risk selection by product differentiation.

Community rating. **Health plans in Connecticut shall be priced based upon the cost of providing health services unrelated to the risk of the insured population, except for two rating factors -- age and geographic area. Geographic area shall be allowable only as it affects the cost differentials related to service provided in different regions of the state. The agency shall establish a risk adjustment methodology for the purpose of insuring that adverse risk selection does not undermine the functioning of purchasing cooperatives and certified health plans.**

Health plans also shall not require an eligible employee or dependent to be subject to medical underwriting, evidence of insurability, or pre-existing condition exclusions as a condition of membership.

Health plans are required to submit data as deemed appropriate for certification by the agency as well as supply data on enrollment and costs as required by the newly created Health Data Institute.

The licensing of insurers and oversight of financial solvency of companies shall continue to be performed by the insurance department.

Bureau of Health Care Access and Uncompensated Care. **This bureau shall be responsible for determining the current level of access to Connecticut's health care system. The goal shall be to achieve universal access to health care in the most cost-effective manner. In addition, the bureau shall be responsible for administering the state's uncompensated care pool as defined by C. G. S. 19a-168b. The bureau shall also be responsible for insuring that all employers comply with the recommendations regarding competitive health plan purchasing cooperatives. The Agency for Health Systems shall study the issue of employer contributions to health plans purchased by cooperatives and report its findings and recommendations to the General Assembly by January 1, 1996.**

Bureau of Health Care Data Collection and Analysis. **The bureau shall be responsible for staffing the Health Care Data Institute. The bureau would also continue to monitor health care costs and supply the necessary data and information needed for the state health plan.**

Connecticut Health Data Institute

The Legislative Program Review and Investigations Committee recommends the creation of the Connecticut Health Data Institute which shall be responsible for the collection of information on the financing and provision of health care. The institute's mission is to create a state-wide data repository for a centralized cost and quality data system which can be used by both the public and private sectors. The data shall include information from health care providers, health care facilities, integrated health plans, and competitive health plan purchasing cooperatives, premiums, claims, enrollment and outcomes. Certified health plans are required to report data deemed necessary by the institute.

The institute shall be governed by a 17-member board that is representative of the provider community, academic institutions involved in medical research, employers, consumers, and insurers. Eight members of the board shall be appointed by the General Assembly as follows: The president pro tempore of the senate, minority leader of the senate, speaker of the house of representatives and minority leader of the house of representatives shall each appoint two members. The other six members shall be appointed by the governor. Members of the board shall be comprised of:

- **2 representatives from hospitals;**
- **3 health plan carrier representatives;**
- **2 consumers;**
- **3 members from a Competitive Health Plan Purchasing Cooperative;**
- **2 physicians;**
- **2 members from an academic research institution; and**
- **3 representatives of state government as follows: the commissioner of the Agency for Health Systems; the commissioner of the Department of Public Health and Addiction Services; and the commissioner of the Department of Insurance, or their designees.**

The Agency for Health Systems shall provide staff for the Health Data Institute, except for the executive director who will be appointed by a majority vote of the Board.

The board is required to establish the methodology for data collection and for providing direction on what data would be useful to the plans, providers, consumers, purchasers, and researchers. The data institute is required to adopt standards for collection of cost, spending, quality, outcome, and utilization data; and for the analysis and dissemination by private sector entities of information on costs, spending, quality, outcomes, and utilization provided to the private sector entities by the data institute. The

board is also required to establish a policy on the confidentiality of data. The board is granted the authority to contract with private organizations to carry out the data collection initiatives.

The health policy council, in consultation with the board of the Connecticut Health Data Institute, is required to develop a Data Collection Plan. The plan must identify:

- **data collection objectives, strategies, priorities, cost estimates, administrative and operational guidelines, and timelines;**

- **encounter level data (data related to the utilization of health care services by and the provision of health care services to individual patients, enrollees, or insureds, including claims data, abstracts of medical records, and data from patient interviews and patient surveys).**

The data institute shall have the authority to levy a charge for data provided.

Competitive Health Plan Purchasing Cooperatives

Competitive Health Plan Purchasing Cooperatives. **The Legislative Program Review and Investigations Committee recommends the establishment of a corporate entity entitled "competitive health plan purchasing cooperative" which is allowed to organize as a non-stock, not-for-profit corporation or as a for profit corporation and whose primary function would be to offer multiple certified health plans to members. The Agency for Health Systems shall set standards for the licensure of competitive health plan purchasing cooperatives (CHPPCs). Competitive health plan purchasing cooperatives shall not be allowed to take insurance risk. If a non-stock, not-for-profit entity is created, the corporation's board of directors shall have employer and employee representation. For profit corporations must form an advisory board composed of employers and employees for purposes of advising the corporation's management.**

It is further recommended that only certified health plans be offered exclusively to competitive health plan purchasing cooperatives.

Cooperatives shall be required to reach a minimum size of 20,000 insured lives within three years of their initial license application to the agency. The cooperatives shall offer at least three certified plans to their members. Cooperatives shall perform, at a minimum, the following functions: 1) enrolling members; 2) collecting and distributing premiums; 3) establishing specifications for contracting of health plans competitively; and 4) providing consumer information on cost and quality of competing plans.

The Agency for Health Systems shall, by regulation, establish appropriate business practices for CHPPCs. The agency shall have the authority to transfer business from a non-functioning entity, as determined by the agency, to a functioning one. The agency shall also insure that requirements established for joining a purchasing cooperative not result in the selection of members or employers by health risk.

Employers. **All Connecticut employers are required to participate in a competitive health plan purchasing cooperative. Employers are free to choose, to join, or to form cooperatives as they deem appropriate and are guaranteed acceptance into any cooperative if they meet the requirements established by the cooperative.**

Access to health care. **The Agency for Health Systems shall study the issue of employer contributions to health plans purchased by cooperatives and report its findings and recommendations to the General Assembly on January 1, 1996. Any employer not joining or forming a cooperative shall be assigned to one by the Agency for Health Systems.**

INTRODUCTION

Health care reform and cost containment efforts need to be based upon the unique nature and composition of a state's finance and delivery system if reform is to be successful. Connecticut's health care system lacks organization but possesses abundant resources and considerably advanced care. Connecticut, as a state, is also fortunate in having one of the highest percentages of insured individuals as well as an extensive base of charity and community care. However, this combination, along with having the nation's highest per capita income, has lead to extreme cost pressures on the medical system.

The goal of the study was to examine the state's current health care market and cost containment strategies and create a regulatory environment and governmental structure that enhances and sets boundaries for the operation of an organized and rational health care delivery system. The proposed regulatory structure is one that will support incentives to allow for the sharing of health risks, extend health care coverage as widely as possible, improve the quality of care delivered, and provide value for dollars spent on health care. An underlying goal of the recommendations of the Legislative Program Review and Investigations Committee is to move Connecticut from a static market and regulatory structure to one that allows dynamic change, based upon adequate information, while preserving the best features of the current health care delivery system. A basic premise of the system proposed is that health risk needs to be spread equally among large groups so that health insurance is available to all at an affordable cost.

The report profiles the health care market in Connecticut and examines trends in the delivery system. By outlining what exists, the legislature can shape a regulatory system that is better suited to the needs of the state.

This report is divided into seven chapters. The first chapter presents an overview of national and state health care costs. The second describes and examines the Connecticut market including the delivery and financing of health care. Chapter III presents national and state information on public opinion surveys. The next chapter outlines Connecticut's regulatory environment and administrative structure. The last three chapters, V, VI, and VII, present the committee's findings and recommendations for a new regulatory environment through the creation of a single state agency to integrate the many components of the health care system as well as a new entity that will provide for large group purchasing of health plans.

Methodology. This study was based upon numerous sources including interviews, literature research, data analysis, legislative research, and public opinion surveys. The committee staff interviewed over 120 individuals representing the health care financing and delivery system. They included large and small employers, health providers, hospital personnel, insurance company employees, agents and brokers, third-party administrators, union health fund representatives, and health policy analysts and researchers. In addition, the committee invited panelists to take part in a forum on health care cost containment in Connecticut that covered the following topics: the Commission on Hospitals and Health Care; the Development of Integrated

Health Care Delivery Systems; Providing Health Care to Small Employers and The Role of Purchasing Cooperatives; the Role of Hospitals in Cost Containment; Providers of Health Care - the Problems of Containing Costs; and Monitoring Health Care Outcomes and Improving Quality.

The study also included site visits to urban and rural hospitals, community health facilities, and various insurance companies and medical practices.

Chapter I: The Cost of Health Care

Escalating costs and problems with access are exerting mounting pressures on the existing American system of health care delivery and finance. Medical costs have been increasing rapidly over the decades and the cumulative effect has been a dramatic rise in the share of national income spent on health care. While numerous attempts have been made to control health care costs both on the state and national level, most have met with only limited success. The section explores some of the major reasons health care costs have continued to rise and compares spending among different states and nations.

A number of factors contribute to the growth of health care expenditures in Connecticut and the U.S. Seven major determinants cited often are: 1) population growth; 2) economy-wide price changes; 3) increases in health care specific prices; 4) demographic mix changes -- such as age -- that affect the amount of health care used and intensity of services needed; 5) the expansion of insurance and third-party payers; 6) costs directly related to technological advancements; and 7) increases in consumer preferences for health care service as a result of income growth.[1] These factors account for most of the growth in total health care dollars spent on the state and national level.

Figure 1 entitled "Six-step Medical Cost Inflation" illustrates the path costs have taken and the influence each growth factor has on the cycle. Four historical trends have tended to stimulate the inflationary cycle beginning in the 1950s with improvements in income and the standard of living. The expansion of third-party payments for health care stimulated demand which resulted in higher prices in the 1960s and 1970s. Capital surplus generated from higher prices, along with scientific research and advances in technology, led to the expansion of health care infrastructure in 1980s. Strong consumer preference for health care and a substantial flow of funds into the delivery system are responsible for the current level of expenditures. Breaking this inflationary chain has proven to be difficult nationally, and particularly in Connecticut where income has consistently remained the highest of all states.

National Health Care Expenditures

The United States dedicates a greater share of financial resources to health care than any other industrialized nation. Health care spending in the U.S. broke the $2 billion a day barrier in 1991. Health care spending has increased faster than overall economic growth for three decades and has absorbed an increasingly larger portion of Gross Domestic Product.

Table 1 compares the U.S. per capita expenditure with that of five other nations. The U.S. expenditure is nearly 45 percent greater than that of Canada. The U.S. also differs from

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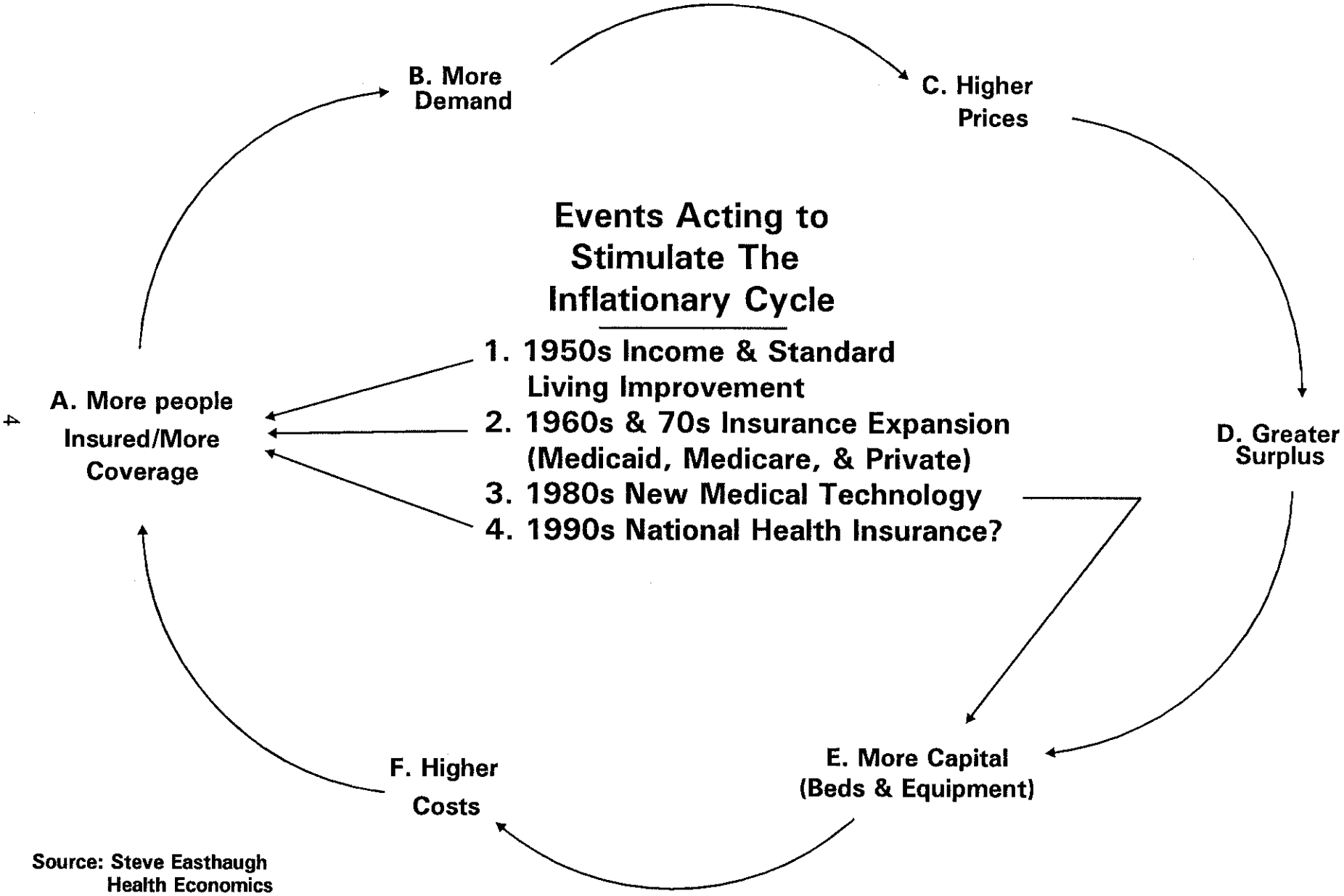
[1] "National Health Expenditure Projections Through 2030", *Health Care Financing Review*, Fall 1992.

Figure 1. Six-Step Medical Cost Inflation Cycle



Source: Steve Easthaugh
Health Economics
1992

other nations in the amount of private funds as opposed to public expenditures that pay for health care. U.S. health care financing is more than twice as dependent upon private funds than any other nation's. Only Switzerland and Austria come close to the U.S. with private funding at 32 and 33 percent, respectively. Health care in the United States is dominated by private insurance paying for health care as part of an employer benefit package. Government funding does play a significant role in health care, but not on the same scale as other industrialized countries as indicated by the last column of the table.

Table 1. Per Capita Expenditures and GDP: A Six Nation Comparison - 1990

Nation	Per Capita Health Expenditure	Percentage Of GDP	Per Capita GDP	Percentage of Non-Government Funds
United States	$2,600	12.2%	$21,271	58%
Canada	$1,770	9.3%	$19,063	27%
Germany	$1,486	8.1%	$18,317	27%
Netherlands	$1,286	8.2%	$15,747	29%
Japan	$1,171	6.5%	$17,994	28%
United Kingdom	$972	6.2%	$15,682	16%

Source: "U.S. Health Care Expenditure Performance: An International Comparison and Data Update": Health Care Financing Review, Summer 1992.

The table also indicates there is a strong correlation between a nation's wealth and spending on health care. As wealth rises so does health care spending. This finding is further supported by a recent study concluding that over 90 percent of the health spending variance can be explained by differences in the level of wealth among countries.[2] Health care is a highly valued consumer service and, as nations become wealthier, their willingness and capacity to invest in health care increases.

National health care expenditures have steadily expanded over the past three decades. The growth rate has increased as more Americans became covered by some form of health insurance. Table 2 contrasts three decades of payment sources for hospitals, physicians, and nursing homes. The table shows dramatic increases in third party payers from 1960 to 1980.

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[2] William J. Moore, et. al., *Measuring the Relationship Between Income and National Health Expenditures*, Health Care Financing Review, Fall 1992, pp. 133-139.

Increases in third party payments were greatest between 1960 and 1970 for all categories of service. As insurance expanded so did the demand for health care services.

As the Table 2 indicates, the expansion of third party payers -- government and insurance -- stabilized in the 1980s, however costs have continued to grow. Table 3 shows national health care expenditures, as a percent of GDP, growing in each decade even though the expansion of third party insurance slowed considerably. Expenditure measures shown in the table have continued to accelerate even beyond the growth of the economy in general. Increases during the 1980s have been attributed to other factors such as growing population, changing demographic characteristics, and the development and use of expensive medical technology.

Table 2. Source of Payments to Major Health Care Providers by Percent Distribution: 1960-89 Historical Change

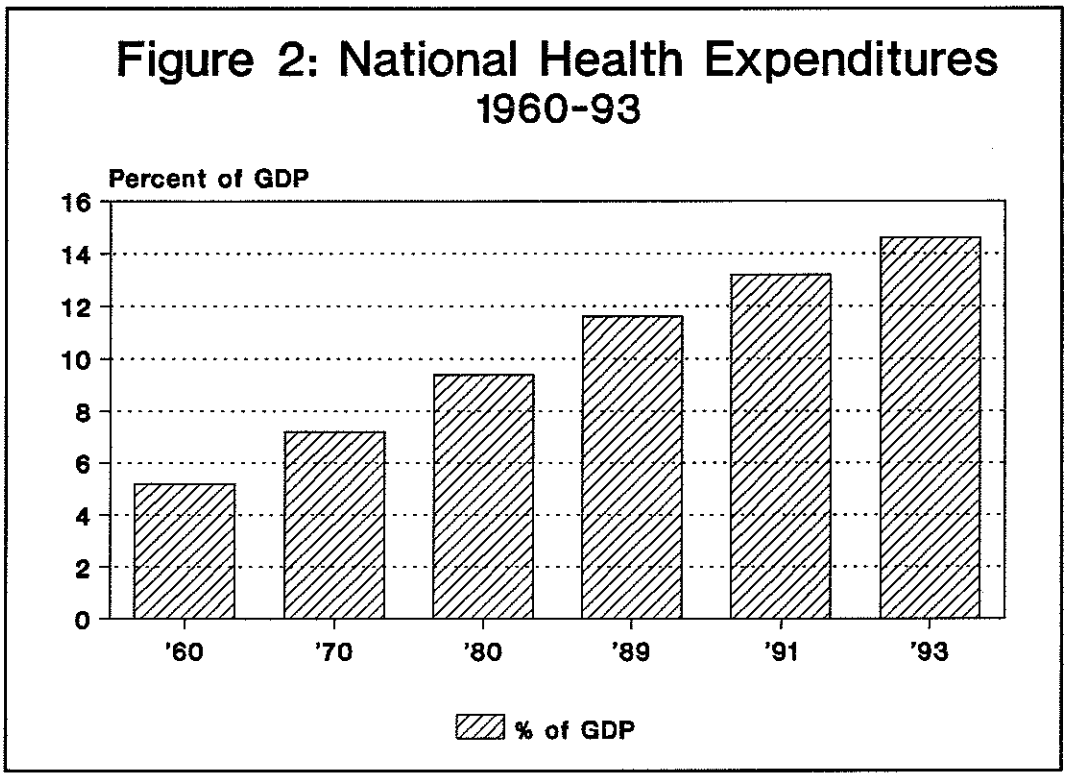
	Hospitals (100%)			Physicians (100%)			Nursing Homes (100%)		
Year	Direct Payment	Government	Insurance	Direct Payment	Government	Insurance	Direct Payment	Government	Insurance
'60	20.4	41.9	36.6	62.3	7.5	30.2	80.0	10.0	10.0
'70	9.0	53.4	37.6	42.6	22.1	35.3	46.9	49.0	4.1
'80	5.2	53.3	41.5	27.0	30.1	43.0	43.5	52.5	4.0
'89	5.5	53.5	41.1	19.0	33.3	47.7	41.5	55.6	2.9

Source: Health Care Financing Review, Vol. 11 (Summer 1990).

Table 3. National Health Expenditures: 1960-93.

Year	GDP*	Health Expenditures*	Health Expenses Per Capita	Health as a Percent of GDP
'60	498.3	$25.8	$142	5.2%
'70	960.2	$69.2	$333	7.2%
'80	2,631.7	$247.5	$1,049	9.4%
'89	5,322.0	$604.4	$2,398	11.6%
'91	5,677.0	$752.0	$2,751	13.2%
'93 Projected	6,255.0	$912.0	$3,257	14.6%

* In billions of dollars.
Source: *Health Care Financing Review*, Vol. 12, (Fall 1991). Congressional Budget Office, May 1993.



Costs to Business and Government. The costs of providing health care to both government and businesses have accelerated rapidly. For business, health care expenditures have increasingly taken a greater share of employee wages and corporate profits. Table 4 shows the percentage increases from 1965 to 1990. Health care expenses have become a significant portion of operating costs for any business providing insurance coverage.

For example, 1965 health insurance expenses represented only 2 percent of the total compensation paid by a company, while in 1990 it rose to 7.1 percent. In 1990, health accounted for 45 percent of fringe benefits. For the first time, in 1990, health expenses were 7 percent greater than the after-tax profits of business. In other words, for every dollar earned as profit, business spent another dollar and seven cents for health care costs to cover employees. In Connecticut, where business provides more insurance to its employees than any other state, these figures can have a significant impact on the private sector economy.

State and federal governments have faced even greater expense pressures. The cost of medicare has risen at a phenomenal rate since the program's inception in 1967. Program costs have gone from $4.5 to $113.9 billion by 1991 and the cost per enrollee has tripled in the last decade alone. The medicare program has put extraordinary pressure on the growth of the federal budget as have medicaid programs on state budgets.

Table 4. Expenditures for Health Care As a Percent of Business Expenses and Profits.					
	Health Expenses as a Proportion of Compensation (Percent)			Health Expenses Compared to Profits (Percent)	
Year	Total Compensation	Wages and Salaries	Fringe Benefits	Corporate Profits Pre-Taxes	After Taxes
1965	2.0%	2.2%	22.4%	8.4%	14.0%
1970	3.1%	3.5%	29.2%	19.8%	36.1%
1975	3.9%	4.5%	28.5%	21.3%	34.3%
1980	4.9%	5.8%	31.7%	27.3%	42.6%
1985	6.1%	7.2%	38.9%	51.3%	89.9%
1990	7.1%	8.5%	45.5%	61.1%	107.9%
Source: Health Care Financing Review, February, 1991.					

Table 5. Medicare Enrollees, Reimbursements, and Cost Per Enrollee.			
Year	Enrollees (millions)	Reimbursements (billions)	Cost Per Enrollee
1967	19.5	$4.5	$233
1970	20.5	$7.1	$346
1975	25.0	$15.6	$625
1980	28.5	$35.7	$1,253
1991	34.8	$113.9	$3,269
Source: U.S. Health Care Financing Administration.			

Where Are Health Dollars Spent and Who Do They Go To?

Table 6 shows spending by health care sector from 1980-1991. Physician expenses have had the largest increase over the eleven-year period, though they consumed only 19 cents of every dollar spent as compared to hospitals at 38 cents. (The category of "other health expenditures" include such items as program administration, public health, research, and the net cost of private insurance -- the cost of insurance minus benefits paid to policyholders).

Table 6. National Health Care By Type of Spending: 1991 (in Billions)				
Type	1980	1991	Growth Rate	% of Total
Hospital	$102	$289	183.3%	38%
Physician	$42	$142	238.1%	19%
Drugs, nondurables	$22	$61	177.2%	8%
Nursing Home	$20	$60	200.0%	8%
All Other	$64	$201	214.0%	27%
Total	$250	$752	200.8%	100%
Source: Congressional Budget Office: May 1993.				

The money to finance health care comes from a variety of sources as noted in Table 7. In 1991, private insurance and out-of-pocket payments by consumers supported the bulk of the spending at $421 billion, 55 percent of the total. The federal share of spending was at 29 percent, while state and local governments provided the balance of funds.

Table 7. National Health Care Expenditures by Source of Funds: 1991 (In Billions)		
Source	1991	Percent of Total
Out-of-Pocket	**$144**	**19%**
Private Insurance	**$244**	**32%**
Other Private	**$33**	**4%**
Medicare	$123	16%
Medicaid (Federal)	$56	7%
Other Federal	$44	6%
Medicaid (State)	$45	6%
State and Local	$62	8%
Total	$752	100%
Source: Congressional Budget Office, May 1993.		

Perhaps the most interesting aspect of health care expenditures is who consumes what portion of health care dollars. Most recently, employers and insurers have noticed that a

relatively small proportion of employees account for a disproportionately large share of the health care costs. In research on how the U.S. dollar is spent[3], several authors concluded that expenditures are concentrated in a small portion of the population. Using numerous data sources the researchers examined the distribution and concentration of health expenditures over time.

For 1980, they found that 1 percent of the population was responsible for spending 29 percent of the health care dollars while 10 percent consumed 70 percent of the costs. In contrast, the half of the population used only 4 percent of the total dollars. By 1987, the concentration of spending increased further with 1 percent absorbing 30 percent of the expenses and 10 percent consuming 72 percent of the health care dollar while the bottom 50 received only 3 percent. In fact, by 1987, 30 percent of the population was responsible for 91 percent of all health care costs.

This finding has led some health policy analysts to conclude there are enormous incentives for private insurers to identify high-cost users and to keep their numbers under control to ensure profitability and stabilize premiums. One noted health policy analyst, Henry Aaron, has said "the concentration of expenditures on a few patients underscores the fact that any measures that successfully reduce the rate of growth of spending on health care must eventually effect outlays on high cost episodes"[4].

Financing Health Care in Connecticut

Health care expenditures in Connecticut were estimated to be $12.75 billion in 1991. The financing of health care in Connecticut breaks down according to the payers cited in Table 8. The largest proportion of payments for health care is provided by employers who self-insure their employees. The next largest payer group is comprised of individuals who make out-of-pocket payments to providers.

While all health care costs are ultimately borne by households, either in the form of direct payments for premiums, lower wages, higher prices for goods and services, taxes, and out-of-pocket expenses, numerous fiscal intermediaries assist in the financing of health care in Connecticut. Figure 3 entitled "Financing Health Care: *The Flow of Funds*" illustrates the movement of funds through the health care system. Households are on one side making payments and on the other are health care providers supplying services. In the middle are various entities charged with collecting and disbursing funds. Those entities include business, government, and insurance funds that transfer money on either a fee-for-service basis or through managed care networks operating in a variety of ways. Funds are also directly transmitted from households to providers as either direct payments or co-payments for services rendered.

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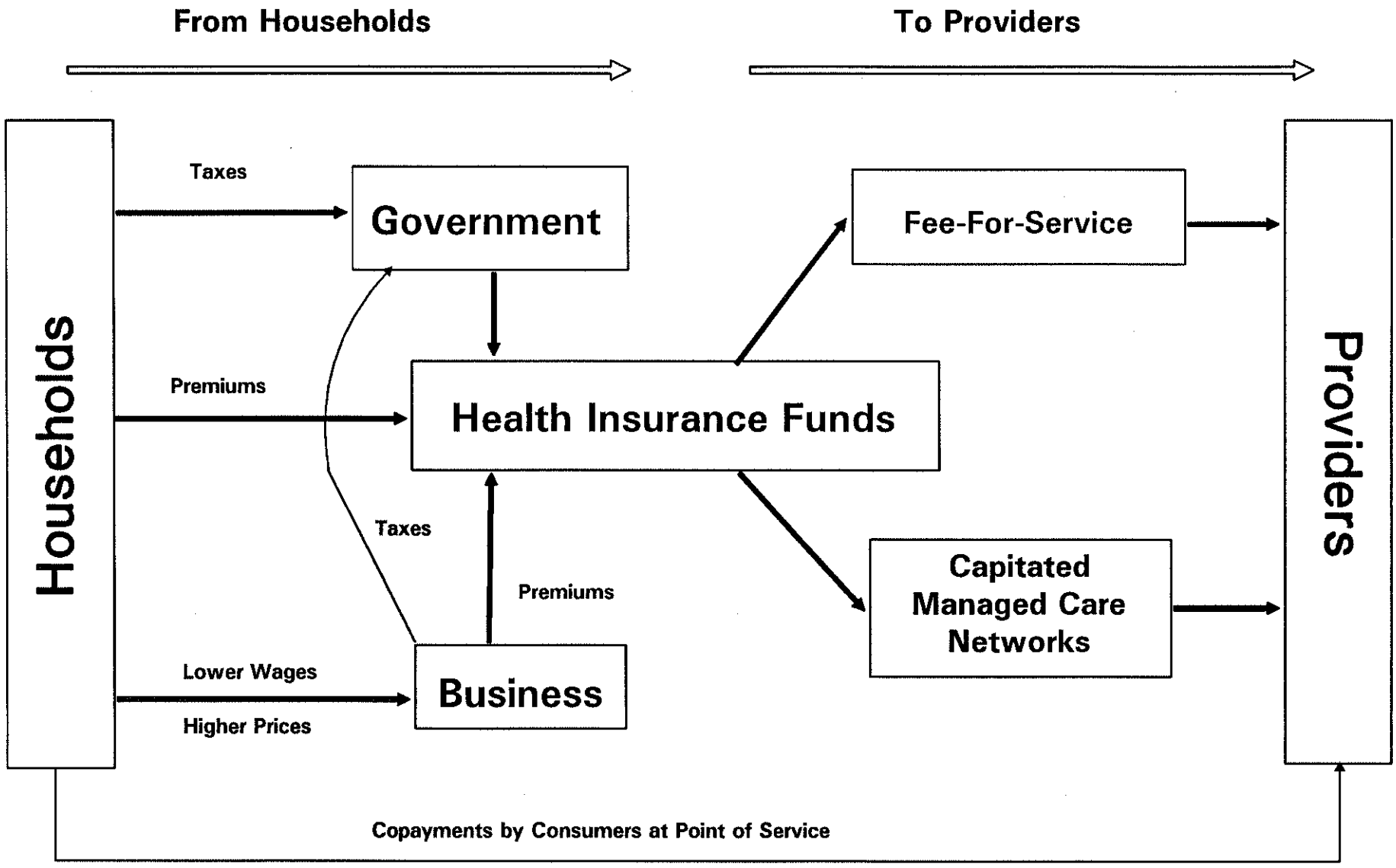
[3] Marc Berk, Alan Monheit and Michael Hagan, **Health Affairs**, Fall 1988 and Winter 1992.

[4] Health Affairs, Winter 1992, p. 146.

Figure 3: Financing Health Care: *The Flow of Funds*



Adapted from: Uwe E. Reinhardt

Table 8. Financing Health Care In Connecticut: 1991 Figures.		
Source of Payment	1991 Billions	Percent of Total
Medicare	$1.612	13%
Medicaid	$1.629	13%
Commercial Insurance	$1.091	9%
Blue Cross/Blue Shield	$1.388	11%
Health Maintenance Organizations	$.953	7%
State Health Programs	$.411	3%
Federal Employees	$.313	2%
Out-of-Pocket Expenses by Households	$1.785	14%
ERISA* Plan Direct Claims Payments and Premium Payments by Employees	$3.57	28%
Total	$12.75	100%
* Employee Retirement and Income Security Act (Self-funded Plans)		

Health Care Costs in Connecticut

Health care costs in Connecticut have consistently been the highest in the nation. In 1980 the state ranked number one in total health care payments per family ($3,252), followed by New York ($3,135), and Massachusetts ($3,088)[5]. In 1991, Connecticut continued to be first at $9,312, while the gap widened with Massachusetts in second place at $8,484 and New York in third at $8,210. In neighboring Rhode Island (ranked 5th at $7,647) and New Jersey (listed 6th at $7,586) costs per family were nearly $2,000 less than Connecticut[6]. The state is projected to hold onto first place through the year 2000 with costs to business and families exceeding $20,000 a year[7]. From 1980 to 1991, Connecticut's costs have risen 201 percent.

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[5] Morgan, Morgan, and Quinto, ***Health Care State Rankings: 1993,*** Morgan Quinto Corporation, 1993, p. 199. (Original source: ***Health Spending: The Growing Threat to the Family Budget,*** Families USA Foundation, December 1991.)

[6] Ibid. p. 198.

[7] Ibid. p. 200.

These costs have clearly put Connecticut at a competitive disadvantage in terms of economic development. Anyone doing business in Connecticut faces higher costs for health care than anywhere else in the country. Given the fact that Connecticut has the second highest rate of insured population at 92.5 percent[8], the costs heavily impact business.

In its 1992 study of health care costs in Connecticut, the Health Care Access Commission determined spending to be largely composed of two areas: hospital care and physician services. Table 9 gives a percentage breakdown of Connecticut spending.

Table 9. Financing Health Spending In Connecticut: 1992 Figures.

Source of Payment	Percent of Total
Hospital Care	41%
Physician Services	25%
Other Spending (Labs, drugs, etc.)	12%
Other Personal Health Care	12%
Nursing Home Care	10%
Total	100%

Sources: Pursuing Health Care Reform In Connecticut, Health Care Access Commission, Lewin-ICF, July 1992.

It should be noted that these are estimates based upon a variety of sources and do not reflect actual costs paid -- data which are not collected in the state. For instance, actual payments to physicians are not available. These estimates are made by extrapolating national data to Connecticut. The only information collected consistently is hospital costs. The hospital care category in the table below includes all hospitals such as private and state specialty facilities, as well as acute-care hospitals, which account for 25 percent of total health care expenditures.

Hospital Costs. Connecticut's health care cost containment efforts have focused on the 25 percent of spending that goes for acute care hospitals. Those costs have continued to rise throughout the 1980s. The total expense per admission for Connecticut hospitals in 1980 was $2,039, slightly below the New England average of $2,209 and above the national average of $1,851. By 1991, the expense per admission was well above the New England and the U.S. averages. The state's expense per hospital admission for 1991 was $6,696, while both the New England average was $5,894 and the U.S. average was $5,360, a substantial difference in

[8] Morgan, Morgan, and Quinto, 1993, p. 179. (Original source: U.S. Bureau of Census unpublished data.)

comparison to those figures. The year-to-year percentage increase exceeded the New England increase for every year from 1981 to 1991, and was greater than the national average 5 out of 11 years.

Table 10. Expense Per Admission*: 1980-91 Year to Year Percent Change.

Year	Connecticut	New England	United States
1980	11.4%	13.1%	12.8%
1981	15.9%	15.3%	17.3%
1982	16.0%	13.8%	15.2%
1983	11.2%	9.9%	11.5%
1984	6.8%	6.7%	7.4%
1985	10.9%	9.1%	8.3%
1986	8.9%	4.9%	8.9%
1987	13.1%	9.6%	9.0%
1988	13.9%	13.0%	9.3%
1989	14.9%	9.2%	9.1%
1990	7.1%	4.9%	7.8%
1991	7.3%	6.9%	8.3%

Source: American Hospital Association: Hospital Statistics: 1978-1992
Provided by the Commission on Hospitals and Health Care.
* [Total Expenses (Inpatient Revenue/Total Patient Revenue)]/Admissions.

When comparing semi-private room charges nationally, Connecticut again ranks number one (Table 11). The following table shows Connecticut's position and costs as compared to the top 15 states. Charges in Connecticut were more than $100 dollars greater than bordering states.

Hospital Capacity. Connecticut ranks low in terms of hospital beds per 100,000 population, 34th out of 50, as well as utilization of beds. Hospital admissions and inpatient days have also declined steadily since 1980. Admissions numbered 423,724 in 1980 and were 354,506 in 1991, a 15 percent decline. For the same period, inpatient days declined even more steeply, by 17 percent, from 3,193,189 to 2,627,311.

In 1992, the occupancy rate for licensed hospital beds in Connecticut was 63 percent of capacity and the rate for beds that were actually staffed was 76 percent. (Hospitals do not use all their licensed beds.) These rates declined from 1989 when licensed bed occupancy was 65 percent and staffed bed occupancy was 79 percent.

Table 11. Hospital Semi-private Room Charges: 1990		
State	Charge	Difference Compared to Conn.
Connecticut	**$456**	**$0**
California	$453	$3
Alaska	$407	$49
Delaware	$385	$71
Vermont	$378	$78
Pennsylvania	$375	$81
Utah	$353	$103
Massachusetts	**$351**	**$105**
Hawaii	$348	$108
Rhode Island	**$342**	**$114**
New York	**$339**	**$117**
Oregon	$338	$118
Michigan	$337	$119
Maine	$335	$121
Washington	$334	$122
Source: Health Insurance Association of America, "Hospital Semiprivate Room Charges Survey, 1989".		

A study done for CHHC on future hospital facility needs[9] indicates that by 1997 Connecticut will have **2,877 excess licensed beds** and 883 excess staffed beds. If the consultant estimates are correct, hospital utilization in Connecticut will drop to 39 percent based upon projected need. The combination of reduced patients and days in the hospital has forced the rate of capacity utilization down. These figures indicate there is excess bed capacity in Connecticut's hospital system and that excess overhead may be a significant factor contributing to costs in the state.

Health care cost will continue to be a major problem for Connecticut well into the future given the expenditure base, system capacity, high level of technology, and the state's wealth.

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[9] *Assessment of Current Health Care Facilities and Future Requirements,* Arthur D. Little, Inc., June 11, 1993.

The challenge will be to develop health reform proposals that allow the market to reduce expenditure growth through competitive forces and maintain high quality health care. The next section closely examines the current state of the Connecticut health care market in light of recent changes that have occurred in a relatively static finance and delivery system.

CHAPTER II: THE HEALTH CARE MARKETPLACE IN CONNECTICUT

Health care reform needs to consider the nature of a state's health care delivery system if it is to be successful. The following section on the health care market presents a broad outline of the way services are delivered and financed in Connecticut. Given the immense size of the state's health care system, proposals for reform need to be put forth that build upon existing operations.

Health services in Connecticut are provided by a loosely structured delivery system organized at the community level and financed by a variety of sources. The delivery of services has been largely provided by individual practitioners or small medical groups and paid for on a fee-for-service basis. Institutional health care is offered by numerous facilities located throughout Connecticut and in bordering states.

Health insurance is provided largely by employers and the government, both state and federal. However, there is no single statewide system of purchasing health insurance. Rather, individuals and families receive coverage through an extensive variety of employer- and government- sponsored benefit plans. These private and public plans differ in benefits covered, sources of funding, and payments to medical care providers.

Individuals without some form of health insurance receive fewer and less coordinated services. Care is provided through community clinics and hospitals, state and local health programs, and private providers. Care not paid for by individuals or health insurance must be paid for out charity funds available to hospitals or passed on to other payers. Frequently referred to as "uncompensated care", this method to a large degree provides health care to the uninsured.

The regulatory structure covering the marketplace is as varied and fragmented as the delivery system. Three major state agencies have jurisdiction over health care services: 1) the Department of Insurance; 2) the Department of Public Health and Addiction Services; and 3) the Commission on Hospitals and Health Care. These three agencies have different responsibilities related to each area of the market. The insurance department is largely responsible for assuring the financial solvency of companies offering health insurance products and approving those products. The health department licenses many health providers and institutions and provides health planning for the health care delivery system. The Commission on Hospitals and Health Care has been responsible for containing costs by regulating the hospital sector through budget and rate review and approval of capital expenditures. A fourth agency, the Department of Social Services, is responsible for providing access to health care for poor and disabled citizens. Section IV of this report provides greater detail on Connecticut's regulatory environment.

While both health care regulatory and market structures in Connecticut have remained relatively static over the last 20 years, in the past two years change has begun to alter the market through development of new relationships among providers, insurers, and employers.

Though the market has begun to shift from a fee-for-service reimbursement system to managed care health plans, there has not been a corresponding shift in the regulatory structure. The current market direction toward more competitive health systems is at odds with an antiquated hospital cost containment regulatory structure. To achieve health care reform, it is necessary to design a government organization that can shape and guide a dynamic, competitive health care finance and delivery system.

The keys to containing health care costs and maintaining high quality are: to provide adequate information on health care outcomes; to control the utilization of services; and to reduce price increases for health care services. These goals must be built into the design of any new health care delivery system. The current delivery system has only begun to address these areas. A careful examination of the way health care is financed and organized in Connecticut will illustrate this point.

Financing Health Care in Connecticut

Connecticut has an array of health insurers, employers, and providers interacting in the system. Two actors that dominate the market are insurers and providers, and understanding their interdependence is important to changing the health care delivery system.

Health insurance is most frequently provided by two sources: the government; and employers. The majority of the state's population has its health care financed by employers through insurance companies, self-insured plans, or the government. Individuals also pay approximately 15 percent of the direct health care expenses and insurance premiums. Ultimately, households bear the full cost of health care through taxes, wages, and the products and services they purchase.

Government sponsored health programs include Medicaid for the poor and disabled, administered by the state, and Medicare for the elderly, which is administered by the federal government. Employers and unions, the largest groups providing private health insurance, have the option of not providing health coverage, providing coverage by self-insuring and/or self-administering a benefits program, or purchasing health insurance in the private marketplace.

Employers. The size of a firm has a significant impact on whether health care coverage is offered to individual employees and families and the type of plans they will be able to obtain. Large firms are more likely to offer insurance as well as a greater array of health plans and better coverage. As size increases, more options become available to both the employee and the employer.

The distribution of private Connecticut firms by size is described in Table 12. More than half of the employees in the state work for companies employing less than 100 individuals. Only 17 percent work for companies employing in excess of 500 workers.

Census population data for Connecticut, which breaks down firm size slightly differently from that provided by the state's Department of Labor, shows only 35 percent of the companies with under 25 employees provided group health coverage. Employees of firms with between 25 and 99 workers were insured at a rate of 56 percent. Seventy-two percent of the firms employing more than 100 workers provided insurance to their employees[10]. It is estimated that 99 percent of the firms with over 500 employees provide health coverage.

Table 12. Private Firm Size and Employment in Connecticut: 1990

Firm Size	1-4	5-9	10-19	20-49	50-99	100-249	250-499	500-999	1000+
No. of Firms	50,694	18,469	11,652	7,286	2,519	1,539	421	147	89
No. Of Employees	89,506	121,735	156,190	219,749	174,979	230,160	142,893	99,188	247,623
Cumulative Percent (employees)	6%	8.2%	10.5%	39.6%	51.4%	67%	76.6%	83.3%	100%

Source: Connecticut Department of Labor.

Firm size also has a significant impact on the type of products offered to employees. Larger firms have been able to offer more managed care health plan alternatives -- medical plans that ask participants to seek care from defined networks of providers and attempt to control utilization of services, while smaller companies offer traditional fee-for-service indemnity insurance plans with large deductibles. Based upon a survey by Foster Higgins on health care benefit plans[11], only 29 percent of the firms with less than 500 employees offered a choice of traditional indemnity (claims-paid only) plans and managed care alternatives (health maintenance and preferred provider organizations). Seventy-one percent of those employers who offered coverage did so through a single health plan. On the other hand, 59 percent of large employers (over 1,000 employees) responding to the survey indicated they offered multiple health plans, both indemnity and managed care alternatives.

The offering of health maintenance organization (HMO) plans is very dependent upon firm size. Foster Higgins reported that of firms under 500 employees only 38 percent offered HMOs, while 93 percent of the firms employing more than 20,000 people were able to offer this cost-effective alternative delivery system. In addition, larger firms also indicated they found greater savings from managed care and utilization review programs than smaller companies.

The advantages larger firms have in selecting and evaluating health plans is clearly evident from a number of indicators. In Connecticut, large companies such as Xerox

[10] Three-year merged average of the Census Population Survey: 1989, 1990, 1991.

[11] Foster Higgins, *Health Care Benefits Survey, 1992: Report 1, Medical Plans.*

Corporation in Stamford and Electric Boat Division of General Dynamics in Groton have been able to reduce their costs by providing employees with a number of plan options and negotiating with provider networks for reduced fees and utilization controls.

Enhancing choice of health plans is clearly an important goal of health care reform and a key feature for effective cost containment. The advantages of size can be magnified by assembling larger groups that allow numerous employers to combine for purposes of purchasing health insurance. Such groups have been operating in Connecticut and will be described later in this report and specific recommendations concerning the creation of "purchasing cooperatives" are made.

Insurers. Organizations that insure against health risk are another principal participant in the health care environment. The health insurance market is composed of a diverse mix of government payers, commercial insurers, health maintenance organizations, Blue Cross/Blue Shield, and self-insurers. By most accounts, the structure of the insurance marketplace should encourage intense competition for the financing of health care. No one has a substantial control over the market, in terms of premiums as shown in Table 13, or as indicated by enrollment estimates found in Table 14. Government, through the Medicaid and Medicare program, controls the largest share of expenditures at 40 percent. The next largest is Blue Cross at 17 percent. It should be noted that some of the HMOs (listed previously in Table 6) are in fact owned by commercial insurers as well as by Blue Cross and are not included in the expenditures and enrollment figures found in the tables 13 and 14.

Table 13. Health Insurance Premiums: 1988 to 1992

Insurance Entity	1988	1989	1990	1991	1992	'88-'92 Percent Change	'92 Market Share
Medicare	$1,147,000	$1,310,000	$1,494,000	$1,612,000	$1,953,460	70%	24%
Medicaid	693,815	816,500	964,800	1,195,800	1,287,100	86%	16%
Long-term Care	*416,997*	*489,420*	*559,004*	*515,650*	*713,536*	*71%*	*9%*
Health Services	*276,818*	*327,080*	*405,796*	*680,150*	*573,564*	*107%*	*7%*
HMOs	519,171	703,401	854,351	942,884	1,034,337	99%	13%
Blue Cross	1,152,641	1,343,647	1,406,247	1,388,693	1,344,355	17%	17%
Commercials	941,166	1,075,189	1,270,618	1,091,932	1,123,724	19%	14%
Total w/o LTC	*4,730,611*	*5,575,817*	*6,395,812*	*6,911,459*	*7,316,540*	*41%*	*91%*
Total	$5,147,608	$6,065,237	$6,954,816	$7,427,109	$8,030,076	56%	100%

The table does not include any self-insurance funds, except those that are included in the Blue Cross premiums.

As Figure 4 illustrates, HMOs have experienced the greatest growth over the period, outdistanced only by Medicaid in 1991 (24%) and Medicare in 1992 (21%). In each of those years, HMOs increased by 10 percent, while at the same time both Blue Cross/Blue Shield and commercial insurers either declined or experienced very small growth (-1% and -14% for 1991, and -3% and 3% for 1992, respectively). Over the five-year period, HMOs nearly doubled, while Blue Cross increased by only 17 percent and the commercial insurers increased by 19 percent. In terms of enrollment, Table 14 indicates that Blue Cross/Blue Shield has the greatest market share at 23 percent, followed closely by HMOs at 20 percent. Government payers, Medicaid and Medicare, contribute another 23 percent of the market. Commercial insurers provide health coverage for 17 percent of the market while several other entities constitute the remaining market share.

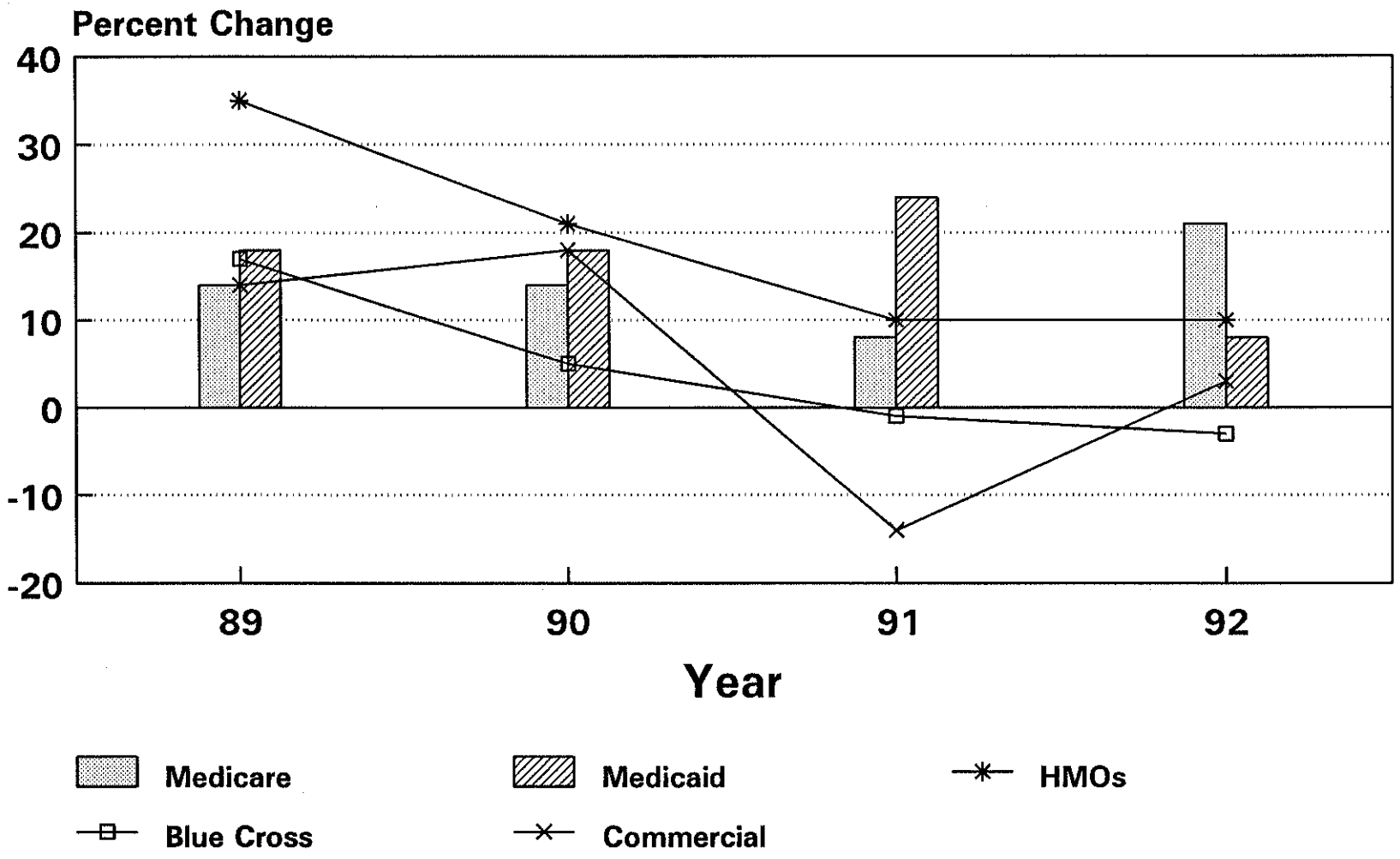
Table 14. Estimated Health Insurance Enrollments: 1992[12]

Form of Insurance	Market Share	Estimated Enrollment
Medicare	15%	485,229
Medicaid		
Long-term Care	1%	21,201
Health Services	7%	233,901
HMOs	20%	635,438
Blue Cross	23%	723,469
Commercials	17%	546,089
Third-Party Administrators	12%	394,816
Coalition of Taft-Hartley Health Funds	4%	132,000
Total	99%	3,172,143

Table 15 describes the marketplace from the perspective of private insurers. Blue Cross is dominant in this market, with slightly over half the premiums. Besides Blue Cross, no one company has more than 10 percent of the market. In total, there are 305 commercial companies licensed to sell health insurance in the state, with the vast majority involved in some form of indemnity plan.

[12] These numbers are derived from a variety of sources and estimates of actual enrollment. Commercial and Blue Cross/Blue Shield estimates are based upon average premiums per employee for preferred provider insurance plans, as reported by Foster & Higgins ($4,246) multiplied by 2.285 (the average household size in Connecticut). Other estimates were provided by organizations representing third-party administrators and Taft-Hartley funds. There is some double counting in that one household may purchase multiple or supplemental insurance plans.

Figure 4: Average Cost Increases
Year-to-Year % Change



While the market for health insurance is diverse with a variety of companies offering plans, there has been a trend toward the development of more organized health plans that not only pay claims but manage care. Employers, seeking to contain costs, as well as insurers and providers wishing to serve the market better, have begun to pursue alternative delivery systems, such as health maintenance organizations and preferred provider organizations. An analysis of this area will assist in understanding the nature of cost containment, quality improvement, and health systems development in Connecticut.

Table 15. Top Ten Commercial Health Insurers: 1992

2 Rank	Company	Earned Premiums (1,000s)	Commercial Market Share
1	BLUE CROSS & BLUE SHIELD OF CT. INC.	$1,344,355	54.5%
2	AETNA LIFE INS. COMPANY	191,383	7.8%
3	TRAVELERS INS. CO. (LIFE DEPT.)	101,385	4.1%
4	GUARDIAN LIFE INS. CO. OF AMERICA	95,542	3.9%
5	PRUDENTIAL INS. CO. OF AMERICA	72,555	2.9%
6	CONNECTICUT GENERAL LIFE INS. CO.	55,511	2.2%
7	FIRST CONNECTICUT LIFE INSURANCE CO.	42,915	1.7%
8	GOLDEN RULE INS. CO.	30,051	1.2%
9	METROPOLITAN LIFE INS. CO.	28,881	1.2%
10	BANKERS LIFE & CAS. CO.	23,447	1.0%
Top 10 Companies: Total		$1,986,025	80.5%
Top 10 w/o Blue Cross		$641,670	25.0%
Total of all Other Companies		$482,054	19.5%
Total: All 305 Companies		$2,468,079	100.0%

Source: National Association of Insurance Commissioners Data Base on Annual Reports.

Health Plans In Connecticut

Financing health care in Connecticut has undergone a transformation over the past decade. The market has moved gradually from health risk underwritten through indemnity insurance plans on a fee-for-service basis to managed health care plans with negotiated arrangements for paying claims to networks of providers for negotiated fees. Unrestricted payments to providers by third-party insurers are widely recognized as a major contributor to

growth rate in health care costs. The primary feature of the new arrangements is the linking of health care finance to the management of health services.

Cost containment. The key to the development of health plans with cost containment strategies involves the organizational structure of service delivery and insurance. Health plans have been moving toward integrated delivery systems to better control price and utilization. The emphasis is on controlling both the price of services as well as the number and intensity of services used.

Organizations offering health plans have adopted two means for controlling costs: 1) managed care and utilization review mechanisms which impose direct controls on unnecessary or inappropriate care; and 2) selectively contracting with providers who have demonstrated a willingness to limit fees, maintain an appropriate style of practice, and share a portion of the risk for a patient's health. These features of organized health plans -- negotiating fees, managed care, and selective contracting -- represent the core processes for cost containment among private health plans.

Health plans are a comprehensive approach to health care delivery and financing. Health plans are concerned with ensuring quality, access, and cost-effectiveness for health care consumers, as well as for providers and payers. An integrated systems can be defined as:

- an organization that has a legal responsibility to deliver medical services to enrolled consumers who seek care from within a network of providers employed by or under contract with the plan;

- an organization that manages care by controlling the patterns of practice of providers in the network through administrative and financial controls.

Managed care health plans administer the delivery of health care services to enrollees through contracts maintained with physicians, specialists, hospitals, pharmacies, laboratories, and other health care providers. The contractual arrangements usually include fixed monthly fees per enrollee or other risk sharing arrangements that give providers a financial incentive to avoid unnecessary utilization of hospital, physician, and ancillary health care services.

Private insurance has designed a variety of ways to provide health care coverage for employees. Entities providing health plans can be divided into four broad classes: 1) unmanaged indemnity plans; 2) managed indemnity plans; 3) preferred provider and exclusive provider organizations; and 4) health maintenance organizations. Further differences can be found within each category and some organizations have a mix of characteristics to meet marketplace demands.

The following table illustrates the range of organizational entities and their involvement in various cost containment strategies.

Table 16. Continuum of Organizational Forms for Health Delivery.						
Indemnity Insurance		Preferred Provider Organizations			Health Maintenance Organizations (HMO)	
Unmanaged/Fee-for-Service	Managed Care Utilization Review	PPO Negotiated Fees	Exclusive Provider Organization	Point-of-Service Plans: Coverage Differential for In/Out of Network Care	POE, IPA and Group Model HMO	Staff HMO

Indemnity. Indemnity insurance plans provide reimbursement on a fee-for-service basis. Under unmanaged fee-for-service plans (FFS), insurers pay specified portion of costs for covered services and allow participants considerable range in their choice of providers. FFS plans typically have deductible amounts which the insured person pays up to 100 percent of the charges as well as a maximum out-of-pocket charges. FFS plans usually pay a specified percentage of the allowable provider charges, with the insured responsible for the balance of the bill. Physician, hospital, and provider charges are directly proportional to the quantity and complexity of the services provided. The more services offered, the more charges incurred and the more revenue generated for the provider. Fee-for-service represents a powerful disincentive for controlling utilization in the health care system.

Preferred provider organizations. A PPO consists of groups of hospitals and providers that contract with employers, insurers, third party administrators, or other sponsoring organization to provide health care services to covered persons for negotiated fee schedules as payment for services rendered.

PPOs are similar to indemnity plans but typically feature discounted fees that have been negotiated by insurers with selected providers. PPOs develop provider networks and reduce costs by obtaining agreements to lower fees in return for patient volume. Enrollees face higher out-of-pocket costs if they use providers that are not part of the organized network. PPOs may also seek to limit the services used by enrollees by creating an utilization review function as part of the health plan.

Two additional plan designs include the point-of-enrollment (POE) and the point-of-service (POS). Under the two designs, employees are given the option of enrolling in either an HMO plan where they are restricted to those providers within the HMO group (POE), or the in a plan that allows them to go outside the network under a cost sharing arrangement (POS). The POS plan allows the consumer to obtain the cost-savings found within a defined network of providers with the freedom to go outside the network while still obtaining partial reimbursement for services rendered. These two new designs have been brought to the marketplace in Connecticut due to consumer resistance to the HMO staff or group model of health care. Both designs, however, have strong components of managed care principles and practices.

HMOs. At the other end of the continuum, as displayed in Table 16, are health maintenance organizations which directly combine financing with the delivery of medicine. Participation provides financial protection for the consumer with very little cost sharing. It does, however, require that medical care be provided by a designated network of providers. The networks can include staff model HMOs or group model HMOs that contract with multi-specialty medical groups to provide services to members. In Connecticut, the most prevalent model HMO is a third type that contracts with independent practice associations composed of individual practitioners who agree to provide services to the members. Group model HMOs and POE health plans are very similar in design.

HMOs provide comprehensive health care services to employees for a fixed monthly premium charged to the employer group. The monthly premium does not vary with the nature, frequency, or cost of services provided. Rather the HMO is required to provide those services within the cost contained environment of a fixed health budget for the group insured. Plans generally charge enrollees a small co-payment for services received.

The distinction between the plans in the continuum presented in Table 5 has become blurred in recent years. Conventional insurers, for example, have taken steps to reduce the costs of their plans by increasing oversight of utilization of services by customers. Insurers have also begun to fill the gap between FFS and HMO plans with preferred provider organizations (PPOs).

Plan costs. In the survey conducted by Foster Higgins, the cost of health care varied widely by the type of plan. According to employers responding, the average cost of an indemnity plan was $4,549 per employee in 1992. Preferred provider plans represent the middle ground in costs at $4,046 while HMOs are the least expensive plans, at $3,591 per employee, to the employer. Most importantly, it should be noted that out-of-pocket employee costs for deductibles, co-payments, and premiums are higher for more costly plans as well, making their actual costs even higher.

Managed care in Connecticut. Managed care has grown significantly over the past five years based upon total premiums and enrollment in HMOs. Table 17 shows total premiums collected by HMOs since 1988. In addition, as Table 18 indicates, HMO enrollment has grown by 32 percent over five years, with total market share second only to Blue Cross. Recently, Blue Cross has begun to move a large share of its business into a new HMO, Enterprise Health Plan, which will further erode the base for indemnity insurance. In addition, there were 77 utilization review companies licensed to do business in Connecticut.

Managed care systems take three basic forms in Connecticut: Health maintenance organizations, organized under the provisions of the federal HMO Act of 1973; preferred provider organizations, organized as insurers; and licensed indemnity insurers who contract with a utilization review company. In recent years, managed care companies have offered a variety of products and services to be more competitive with indemnity insurance. In addition to the standard HMO and preferred provider design, noted above, the industry in Connecticut has begun to offer point-of-service (POS) and point-of-enrollment (POE) plans. The intent of the

new products is to satisfy consumer demand for choice while maintaining the cost containment features of managing utilization and price.

Table 17. Health Maintenance Organizations: Premiums.

	1988	1989	1990	1991	1992
AETNA HEALTH PLANS OF SNE, INC.	$2,725,879	$13,655,380	$26,370,606	$33,921,649	$38,571,677
CIGNA HEALTH PLAN OF CT, INC.	37,655,693	62,311,455	68,074,731	90,746,664	102,884,702
COMMUNITY HEALTH CARE PLAN (Blue Cross Co.)	91,507,928	104,771,287	95,896,860	94,522,717	88,484,506
CONNECTICARE INC.	58,516,806	81,040,939	121,609,276	157,546,295	187,818,578
CONSTITUTION HEALTH NETWORK, INC. (Blue Cross Co.)	95,122,660	100,265,050	171,712,923	163,943,852	175,642,305
HEALTHCARE[1]	69,529,300	78,783,689	N/A		
KAISER FOUNDATION HEALTH PLAN	27,681,739	43,289,859	55,619,163	64,556,830	71,074,782
M.D. HEALTH PLAN, INC.	4,956,360	19,822,739	51,119,156	80,336,879	104,177,374
PARTNERS HEALTH PLAN[2]	2,725,879	13,984,645	26,021,618		
PHYSICIANS HEALTH SVCS. OF CT. INC.	119,488,592	166,785,717	210,422,796	224,670,926	216,662,471
PRUDENTIAL HEALTH CARE PLAN OF CT.	0	1,331,190	2,698,911	2,897,478	4,094,336
SUBURBAN HEALTH PLAN, INC.	1,643,489	2,341,040	2,743,520	3,002,229	3,706,810
U.S. HEALTHCARE, INC.	4,156,915	10,522,894	16,929,785	21,010,329	34,694,985
HEALTH REINSURANCE ASSOCIATION	3,460,377	4,495,872	5,131,856	5,728,742	6,524,712
ENTERPRISE HEALTH PLAN (Blue Cross Co.)[3]	N/A	N/A	N/A	N/A	N/A
OXFORD HEALTH PLANS[3]	N/A	N/A	N/A	N/A	N/A
TOTALS	$519,171,617	$703,401,756	$854,351,201	$942,884,590	$1,034,337,238

[1] Merged with Constitution Health Care, Inc.
[2] Merged with Aetna Health Plans.
[3] Newly licensed HMOs.

Table 18. Health Maintenance Organizations: Enrollment.		
	1988	1993
AETNA HEALTH PLANS OF SNE, INC.	4,617	43,806
CIGNA HEALTH PLAN OF CT, INC.	47,303	80,772
COMMUNITY HEALTH CARE PLAN	71,940	44,907
CONNECTICARE INC.	62,842	118,594
CONSTITUTION HEALTH NETWORK, INC.	158,538	85,557
KAISER FOUNDATION HEALTH PLAN	38,006	46,329
M.D. HEALTH PLAN, INC.	8,144	78,524
PHYSICIANS HEALTH SVCS OF CT INC.	111,710	136,921
PRUDENTIAL HEALTH CARE PLAN OF CT	0	3,905
SUBURAN HEALTH PLAN, INC.	1,618	2,735
U.S. HEALTHCARE, INC.	5,441	29,442
TOTALS	510,159	671,492

The Provider Market

Besides having a diverse and potentially competitive health care financing system, there is also generally an adequate supply of providers in the state. Connecticut has over 80,000 licensed health professionals providing health care services and numerous institutions and facilities also providing health care (Table 19). In two key areas, physicians and hospitals, Connecticut ranks near the top of the nation in measures related to supply.

Health care is provided in numerous settings, many of which are licensed by the state. Licenses are issued for health care "institutions" which are defined as hospitals, nursing homes, homes for the aged, health care facilities for the handicapped, home health care agencies, infirmaries, mental health facilities, and facilities engaged in the provision of services for the prevention, diagnosis, treatment or care of human health conditions. With the exception of solo or group physician practices, whose individuals are licensed as health professionals, almost all centers providing health care in the state require licenses.

Physicians. Connecticut has an abundant supply of physicians, ranking fourth highest in the nation based upon the ratio of physicians to population. In 1990, the state had 263 physicians involved in patient care per 100,000 population. The national average was 196

physicians per 100,000. Connecticut ranks high in all categories of physicians' specialization except general/family practitioner. Table 20 shows the distribution of physicians throughout the northeast.

Table 19. Licensed Health Care Professionals with Membership in Excess of 1,000 in Connecticut: 1993.

Profession	Licenses Issued
Registered Nurses[1]	47,070
Physicians/Surgeons	11,159
Licensed Practical Nurses	11,058
Pharmacists[2]	4,110
Dental Hygienists	3,000
Dentists	2,871
Physical Therapists	2,640
Speech Pathologists	1,408
Psychologists	1,309
Other Licensed Professionals	2,623
Total Licensed Professionals	87,278

[1] Includes advanced practice nurses.
[2] Licensed by the Dept. of Consumer Protection and the Commission of Pharmacy.

As do all northeastern states, with the exception of Maine, Connecticut consistently ranks among the top 20 states in physicians to population ratios, lacking only in the area of general or family doctors. However in two closely related areas, internists and pediatricians, Connecticut numbers fourth, a high ranking.

Given the supply of physicians, one would expect intense competition for patients. Some studies have shown that as the supply of physicians have grown so have medical costs, due in part to the traditional fee-for-service medicine that has dominated physician practice in the northeast. Changing financial incentives -- moving toward managed care and organized networks of providers -- will have a dramatic impact on a market place with such a large supply of practitioners. This is beginning to take place in the region as networks develop and physicians compete for patient volume. Competing integrated networks and health plans have tremendous potential to impact costs in regions, such as Connecticut, where there is a plentiful supply of providers.

Table 20. Physician to Population Ratios: 1990 Northeast States.												
State	Total Physicians		General/ Family[1]		Medical Specialist		Internal Medicine		Pediatrics		Surgical	
	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate	Rank	Rate
Massachusetts	1	280	50	16	1	130	1	79	3	110	4	69
New York	2	275	46	19	2	120	2	60	2	112	2	72
Connecticut	4	263	48	17	4	113	4	65	4	104	3	70
Vermont	5	225	14	34	7	83	6	50	8	71	7	60
Rhode Island	6	223	49	17	5	107	5	63	6	96	6	60
New Jersey	7	221	47	19	6	95	7	50	5	99	8	60
Pennsylvania	8	215	24	30	8	78	8	44	12	62	11	56
New Hampshire	18	185	28	28	19	61	19	33	15	59	20	50
Maine	30	163	12	34	33	48	30	25	28	47	38	42

[1] Minnesota ranks first in this category with 44 physicians per 100,000 population.
Source: American Medical Association, *Physician Characteristics and Distribution in the U.S.*, 1991 Edition and *Health Care State Rankings: 1993*, Morgan Quinto Corporation.

Hospitals. Like physicians, Connecticut has a generous supply of community hospitals that are geographically dispersed and an abundant supply of hospital beds as well. Connecticut ranks fourth behind New Jersey, Massachusetts, and Rhode Island in the number of community hospitals per 1,000 square miles. At 6.31 hospitals per 1,000 square miles, we are more than 4 times the national average of 1.42 hospitals, making access to hospitals, in terms of distance, extremely convenient for most of the population. The state ranks third in the average number of beds per hospital at 275, nearly twice the national average of 172 beds for each hospital. Economies of scale studies of hospitals generally indicate the larger the hospital the more cost efficient it is likely to be.

Hospitals in Connecticut do have excess capacity for inpatient services which should further enhance competitive pressures. The average occupancy rate for staffed beds for 1992 was 73.3 percent. Two-thirds of the hospitals in the state fall below 80 percent capacity indicating that there is currently excess capacity in the system. As noted earlier, a recent study[13] for the Commission on Hospitals and Health Care found that hospitals, by 1997, will

[13] *Assessment of Current Health Care Facilities and Future Requirements,* Arthur D. Little, Inc., June 11, 1993.

have **2,877 excess licensed beds** and 883 excess staffed beds. Based upon utilization estimates, hospital use could drop to 39 percent by that year.

There will be strong market incentives forcing hospitals to join integrated networks, as well as altering the services they perform, to maintain patient volume while reducing expenses. Given the supply of providers, health plans will be well positioned to obtain negotiated agreements with hospitals on the utilization of services and the prices charged for those services, something the regulatory system has found difficult to achieve. The recommendations in the last three sections of the report build on emerging managed care delivery systems to develop a cost-effective vehicle to serve the state's health needs.

CHAPTER III: THE PUBLIC'S PERSPECTIVE ON HEALTH CARE

The cost of health care is ultimately borne entirely by the public. In many ways, the current health care system, both in Connecticut and the nation, reflects consumer preferences, though physicians have historically dominated decisions involving cost and use. More recently, individuals have increased their awareness of the way health care is provided and funded. As reforms in the system are implemented, consumers will be asked to exercise a greater role in determining health care choices in turn impacting the cost of health care. As the public plays an increasingly significant role in the system, measuring their attitudes and opinions takes on expanded importance.

Program review committee staff assembled responses from a variety of public opinion polls conducted by national polling organizations and from the state's own Connecticut Poll[14]. Individuals were surveyed on overall satisfaction with the U.S. health care system and were also asked specific questions about health care financing and delivery. The surveys analyzed by committee staff were conducted in March 1993 and February 1994. Survey results, presented below, emphasize that cost and quality are the American public's major areas of concern.

The overriding dilemma posed by the American people is that they are dissatisfied with the health care system in general, but are pleased with their own health care choices. Survey respondents perceived the care delivered to themselves and their families satisfactorily, while the health care available to the rest of the country was viewed with dissatisfaction. Recent Gallup and Yankelovich polls illustrate the predicament confronting reform of health care.

Personal satisfaction. Two survey questions (Table 21 and Table 24) queried individuals about the quality of care they received. In both surveys, the majority of respondents (81 percent and 74 percent) were satisfied with the quality of care received by them or their families. Table 22 shows that 70 percent of respondents were also satisfied with the health insurance coverage they held. When individuals were surveyed on satisfaction of their personal health care services, 76 percent were either very satisfied, or somewhat satisfied (Table 23). Major concerns include both cost and quality of care as illustrated in Table 25.

The five questions presented below confirm that the public is generally satisfied with their personal health care. However, opinion shifts dramatically when asked about the condition of the nation's health care system.

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[14] The Hartford Courant/Institute of Social Inquiry *Connecticut Poll*, conducted by the University of Connecticut, Storrs, Connecticut.

Table 21.	
Are you generally satisfied, or dissatisfied with the quality of the health care you receive?	
Satisfied	81%
Dissatisfied	17%
Don't Know/Refused	2%
Source: Gallup Organization, May 1993, For CNN/USA Today. Sample Size: 1,011 National Adults.	

Table 22.	
Are you generally satisfied, or dissatisfied with health insurance you receive?	
Satisfied	70%
Dissatisfied	25%
Don't Know/Refused	5%
Source: Gallup Organization, May 1993, For CNN/USA Today. Sample Size: 1,011 National Adults.	

Table 23.	
How satisfied are you with the health care services which are available to you now?	
Very Satisfied	31%
Somewhat Satisfied	45%
Not Satisfied	22%
Not Sure	5%
Source: Yankelovich Partners Inc., March 1993, For Association of Private Pension & Welfare Plans. Sample Size: 1,000 National Adults.	

Table 24.	
On the whole, are you satisfied or not satisfied with the quality of the health care available to you and your family?	
Satisfied	74%
Dissatisfied	24%
Don't Know/Refused	2%
Source: CBS News/New York Times, March 1993. Sample Size: 1,386 National Adults.	

Table 25.	
For your personal health care and that of your family, which of the following is your biggest concern: The cost, quality or availability?	
Cost	50%
Quality	37%
Availability	11
Don't Know/Refused	2%
Source: Gallup Organization, March 1993. Sample Size: 755 National Adults.	

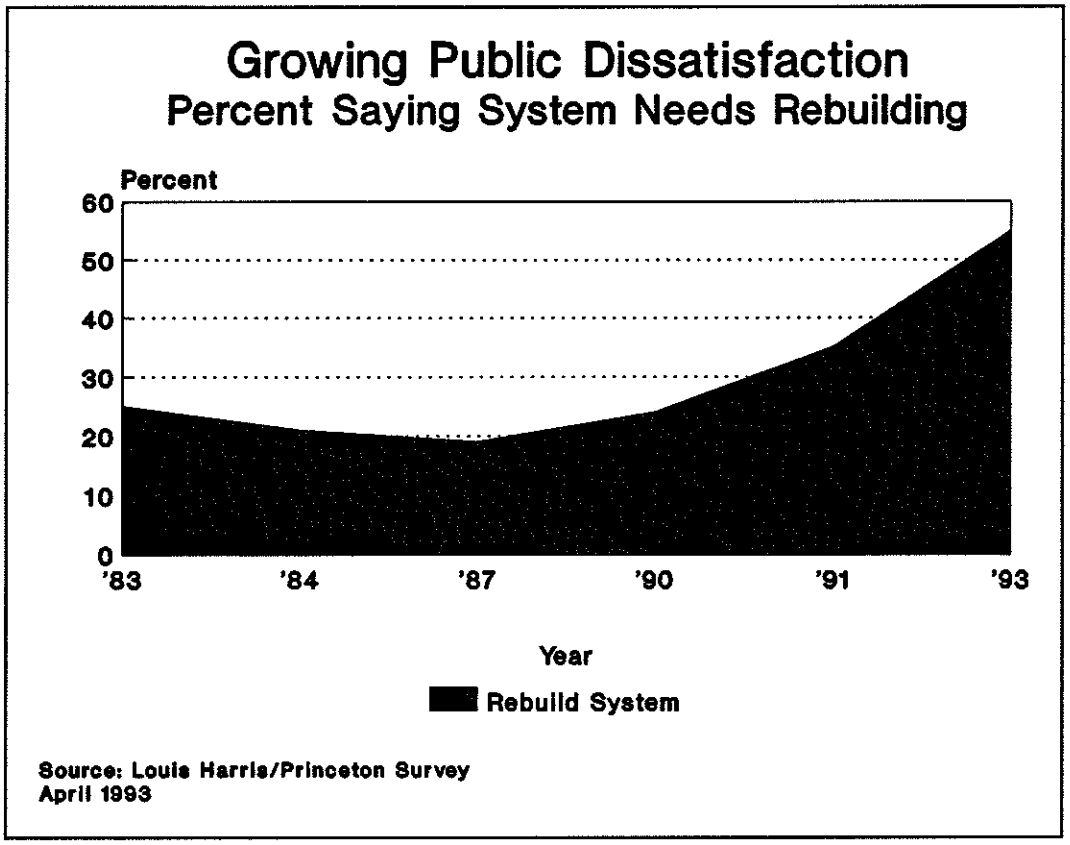
Health care system dissatisfaction. Several recent surveys have shown widespread dissatisfaction with the health care system in general when it is not directly tied to attitudes based on individual consumption of services. It appears that people do not apply their personal experiences to the overall health care system.

The deterioration of public confidence in the health care system over the past 10 years is presented in the figure on page 36. Since 1987 there has been a marked increase in the percentage of the public that believes the system needs to be rebuilt. The highest level of public confidence in the system existed in 1987 when only 19 percent of the respondents thought the system needed to be rebuilt. However, since then, that figure has risen dramatically to 55 percent.

The dissatisfaction in the system is also apparent in several recent surveys that asked an assortment of questions on the state of health care. On overall satisfaction, Table 26 shows that almost half of the survey respondents were not satisfied with the country's health care system.

Table 26.	
How satisfied are you with the country's health care system overall?	
Very Satisfied	9%
Somewhat Satisfied	37%
Not Satisfied	49%
Not Sure	5%
Source: Yankelovich Partners Inc., March 1993, For Association of Private Pension & Welfare Plans Sample Size: 1,000 National Adults.	

Cost of Health Care. The cost of health care is the most pressing public concern. Polling results that dealt specifically with cost issues found it to be the single most important



negative aspect of health care. The survey results found in Table 27 show overwhelming dissatisfaction (90 percent) with the cost of care greater than any other single item. While survey questions on costs almost always elicit negative responses, the large percentage indicates that in the opinion of most, controlling costs must be essential to reform efforts.

Table 27.	
Are you generally satisfied, or dissatisfied with the total cost of health care in this country?	
Satisfied	8%
Dissatisfied	90%
Don't Know/Refused	2%
Source: Gallup Organization, May 1993, For CNN/USA Today. Sample Size: 1,011 National Adults.	

Quality of care. On the other hand, the public is ambivalent on the question of satisfaction with the quality of the nation's health care. Table 28 shows that individuals were evenly split, with 51 percent being satisfied, and 46 percent being dissatisfied with health care quality in this country. While quality is generally considered important by most, consumers believe that they have more control over quality than cost through their selection of physicians and other health care providers.

Health insurance. Along with costs, the public identifies insurance coverage and premiums as important health care issues. When survey respondents were asked about monthly premiums for coverage (Table 29), 27 percent said they paid none, 50 percent paid some and, 20 percent said they paid the entire cost. This question was asked only of those who indicated that they had some form of insurance coverage. The survey found that 86 percent of the national population (Gallup, April 1993, 1006 adults) has some form of coverage. The survey also found that 48 percent had seen their monthly insurance premium costs increase in the last two years while 4 percent had seen a reduction.

Table 28.

Are you generally satisfied, or dissatisfied with the quality of health care in this country?	
Satisfied	51%
Dissatisfied	46%
Don't Know/Refused	3%

Source: Gallup Organization, May 1993, For CNN/USA Today.
Sample Size: 1,011 National Adults.

Table 29.

What is your primary source of health care coverage?	
Through your employer	49%
Through your spouse or partner's employer?	20%
Insurance directly bought by an individual	10%
Medicare	16%
Medicaid	2%
Don't Know/Refused	1%

Source: Gallup Organization for Consumer Union, March 1993.
Sample Size: 1,006 National Adults.
Note: Question was asked of those who had health coverage (86%).

Consumers also found other changes in their coverage that affected their health care. Of the 78 percent of the respondents who said they pay some form of a deductible or co-payment, 26 percent reported an increase in the amount of deductibles or co-payments they were required to pay for doctor bills. One-third of the respondents also said that their health insurance limited their choice of doctors.

The Gallup survey further broke down the source of insurance coverage among individuals responding to the survey. The largest percentage of individuals (49 percent) received their insurance coverage through their employer, followed by coverage through a spouses' employer (20 percent). Medicare provided coverage for 16 percent of the survey respondents.

Individuals were also asked to identify the type of plan that provided their health care coverage. The difference between traditional insurance, health maintenance organizations (HMO), and preferred provider organizations (PPO), were explained to the respondents. The findings were as follows:

Table 30.

Traditional policy	55%
HMO	22%
PPO	14%
Other	3%
Don't Know/Refused	6%

Traditional health care plans are usually considered indemnity insurance plans where the carrier insures the risk and pays the bill without any intervention into the necessity for the services provided. This form of insurance continues to dominate the financing of health care.

American Attitudes on Health Care Reform

The Robert Wood Johnson Foundation (RWJ) and the Harvard School of Public Health[15] recently conducted an extensive survey on American attitudes toward health care reform. The survey was conducted in March 1993 and a national sample of 2,000 adults was polled. The results from this survey provide similar findings as did other surveys analyzed earlier in this section. They found that a majority of Americans, 56 percent, believe the system needed a "complete overhaul", 54 percent were worried about costs, and 60 percent indicated they would likely be paying more personally for health care under any reform measures passed by Congress.

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[15] *American Attitudes Toward Health Care Reform*, Martilla and Kiley, March 18-23, 1993, Available from the Roper Center for Public Opinion Research, University of Connecticut, Storrs, Connecticut.

Seventy-three percent of the respondents felt the quality of health care would stay the same or be better under health care reform.

Like the previous surveys, the RWJ Foundation and Harvard found strong consumer satisfaction with their own health care. Specifically, 84 percent were satisfied with their ability to obtain routine medical services, 80 percent were satisfied with the quality of care they and their families received from hospitals, and 69 percent were satisfied with their ability to obtain advanced medical services.

On specific questions of how difficult it is to pay for health care costs the RWJ and Harvard study found the following:

Table 31.	
How much of a problem is it for you to pay your health care costs that are not covered by insurance or government benefits?	
Very serious	20%
Problem, not serious	30%
Not much of a problem	49%
During the past two years, has the amount of money you and your family spent on out-of-pocket costs not covered by insurance or government benefits gone up a lot, gone up a little, stayed the same, or gone down?	
Gone up a lot	31%
Gone up a little	30%
Stayed the same	33%
Gone down	2
Not sure	4%
Source: Robert Wood Johnson Foundation and the Harvard School of Public Health Sample Size: 2,000 National Adults (95% confidence interval with +/- 2.5% error).	

Table 32 shows that fault for rising health care costs is spread fairly evenly across a number of groups. The one notable exception is that patients believed that they share little of the responsibility for inflated costs. Lawyers were held accountable for costs by 46 percent of those polled, thus receiving the largest share of the blame.

Health care reform. When individuals were asked what the goals of reform should be, the two suggestions receiving the highest priority were: 1) eliminating waste and inefficiency (considered very important by 86 percent); and 2) ensuring those with coverage do not lose it when they change jobs, get laid off, or retire (very important for 83 percent).

On the specifics of reform, there was much less consensus. There is generally strong opposition (54 percent strongly opposed) to limiting certain types of medical procedures (transplants and hip replacements) to the elderly, as well as opposition to limiting the individual choice of doctors and hospitals (50 percent strongly opposed and 20 percent somewhat opposed). On the question of whether older people having a terminal illness should continue to receive extraordinary efforts to keep them alive, 34 percent strongly favored no longer making such effort, while 31 percent strongly opposed it. This is a dilemma affecting health care costs that the public will have great difficulty resolving.

Table 32.	
Which one or two groups do you think is most to blame for rising health care costs?	
Insurance Companies	35%
Doctors	36%
Hospitals	22%
Government	20%
Lawyers	46%
Drug Companies	19%
Patients	4%
Not sure	3%
Source: Source: Robert Wood Johnson Foundation and the Harvard School of Public Health Sample Size: 2,000 National Adults.	

The following table illustrates the factors chosen by the public as the most important reason for rising costs. The table indicates the percentage of respondents who felt the reason listed was a "very important" contributing factor. Greed and profits, malpractice lawsuits, and waste and inefficiency were cited most often as factors for increasing costs.

In a poll done by Louis Harris and Associates in March 1993 there was strong support for giving people the option to pay more for care of their choice (51 percent strongly support and 32 percent somewhat support) and for creating new purchasing cooperatives to bargain for lower health insurance rates (54 percent and 32 percent respectively).

On the question of setting limits in health costs and price controls the Harris poll also found substantial support. Fifty-five percent strongly supported limits on price increases for insurance premiums, 86 percent supported short-term price controls on doctors, hospitals and drug companies, and 84 percent favored the federal government gradually imposing limits on

health care spending to keep health care costs in line with the rate of overall inflation of the general economy. Perhaps the most important finding of the Harris poll lies in the public's overwhelming sentiment (88 percent) that government "should give a lot of attention" to the health care issue.

Table 33.

What contributes to the rising costs of health care?

Reason	Percent Saying It Is Very Important
Waste and Inefficiency	61%
Large number of highly skilled, high priced medical specialists	47%
Malpractice lawsuits	64%
People don't pay for health care directly	34%
Need for research to treat serious new diseases	61%
Expensive, high-tech medical equipment	47%
Greed and high profits	67%
Drugs, alcohol, violence	47%
Growing number of elderly	49%

Source: Source: Robert Wood Johnson Foundation and the Harvard School of Public Health
Sample Size: 2,000 National Adults.

Connecticut Opinion

Polling on the issue of health care has not been done as extensively in Connecticut as it has been done nationally. However, a recent poll done by the Institute of Social Inquiry at the University of Connecticut has begun to ask questions similar to those posed by major national polling organizations. The Connecticut Poll[16], conducted in February 1994, yields results much the same as those reported earlier for the national population samples.

[16] The **Connecticut Poll** is sponsored jointly by the Institute of Social Inquiry at the University of Connecticut and the Hartford Courant. The poll was conducted between January 25th and February 1, 1994 on a population of 500 randomly selected adult residents. The poll carries a margin of error of +/-5 percent.

On the key question of satisfaction with medical care, the survey found that 81 percent of the state's population is either very satisfied or somewhat satisfied with the quality of care they receive (see Table 34). Ten percent were somewhat dissatisfied and only eight percent were very dissatisfied. A similar response was elicited on the question of availability: 88 percent were satisfied, more than half (55 percent) were very satisfied. The question of cost did present a problem to more than half the population, however, with 60 percent indicating dissatisfaction and only 38 percent satisfied with the cost of medical care provided them.

Table 34.

How satisfied are you with the following in terms of medical care received?

	Quality	Availability	Cost
Very Satisfied	50%	55%	17%
Somewhat Satisfied	31%	33%	21%
Somewhat Dissatisfied	10%	6%	27%
Very Dissatisfied	8%	5%	33%
Don't Know	1%	1%	2%

Source: The Hartford Courant/Institute of Social Inquiry Connecticut Poll, University of Connecticut, February 1994.

Table 35.

Compared to the job done by the private sector -- that is, insurance companies, hospitals, and physicians -- do you think the federal government would do a much better job managing health care in this country, a somewhat better job, somewhat worse, or much worse?

Much Better Job	7%
Somewhat Better Job	31%
Somewhat Worse Job	21%
Much Worse Job	29%
About the Same	5%
Don't Know	8%

Source: The Hartford Courant/Institute of Social Inquiry Connecticut Poll, University of Connecticut, February 1994.

When state residents are queried on whether or not there is a health care crisis in this country, the responses are similar to those found on the national level. While people are generally personally satisfied with their own health care they characterize the system as one in need of reform. In this state, 64 percent said they would describe the health care system as one in crises while one third would not.

Connecticut does lean toward private sector solutions to the health care crisis by at least a small margin. The question in Table 35 was asked to determine who could do a better job at managing health care with the private sector slightly favored over government. The relationship between government and the delivery of health care is complex and not easily portrayed in a single question. However, the sentiment in Connecticut is to look for private sector answers to system problems if one considers that only 7 percent feel government will do a much better job while 29 percent felt that it would do much worse in managing the state's health care system.

CHAPTER IV: AN OVERVIEW OF CONNECTICUT'S HEALTH CARE REGULATORY ENVIRONMENT

Health care expenditures in Connecticut were estimated to be $12.75 billion in 1991. The state's Health Care Access Commission also found that 50 percent of the total health care costs could be divided into two areas: acute care hospitals (25 percent) and physician services (25 percent). Connecticut cost containment efforts have focused primarily on regulating acute care hospital expenditures and services. However, the state has a variety of roles in the delivery and financing of health care including protecting public health, safeguarding the consumer in the purchase of health insurance, guaranteeing the financial viability of health insurers, and providing access to health care for certain low-income families, as well as the aged, blind, and disabled individuals.

Four state agencies have a major role in regulating Connecticut's health care delivery system: the Department of Public Health and Addiction Services; the Department of Social Services; the Department of Insurance; and the Commission on Hospitals and Health Care. In addition, the federal government has a critical influence on the health care market through the Medicare health insurance program, and a number of private accrediting associations also shape the delivery system. It is important to understand the way these agencies impact the delivery of health care in Connecticut. Each agency has a significant influence on how health care is provided to the citizens of the state.

Department of Public Health and Addiction Services (DPHAS)

The health department is mandated to protect, preserve and enhance the public's health by ensuring that quality care is provided to consumers. The department achieves this mandate in part through testing and licensing health professionals and health care facilities. Every direct health provider in Connecticut must be licensed by a board or commission having jurisdiction over the field. Each facility providing health care services must also be inspected and licensed by the department.

Health professionals. Specifically, the department assists various boards and commissions by administering licensing exams, holding disciplinary hearings, providing administrative support and personnel, and processing licensing applications. Licensing of health professionals is intended to protect the health and safety of Connecticut residents. All professionals must meet minimum standards of education and experience to qualify for exams administered by the agency. Once professionals are licensed, the various boards and commissions under the DPHAS are responsible for assuring continuing competence through the handling of complaints concerning bad practices. The boards and commissions are empowered to take disciplinary actions against individuals operating outside the standards of professional conduct.

The following table provides the number of currently licensed health care professionals in the state. Nurses and doctors make up the majority and deliver a significant proportion of health care. However, the total by no means represents all employment in health care as there are thousands of individuals involved in ancillary and administrative aspects ranging from housekeeping to institutional management.

Table 36. Licensed Health Care Professionals in Connecticut: 1993

Profession	Licenses Issued
Registered Nurses[1]	47,070
Physicians/Surgeons	11,159
Licensed Practical Nurses	11,058
Pharmacists[2]	4,110
Dental Hygienists	3,000
Dentists	2,871
Physical Therapists	2,640
Speech Pathologists	1,408
Psychologists	1,309
Chiropractic Physicians	796
Optometrists	601
Opticians	523
Podiatrists	393
Osteopathic Physicians	150
Nurse Midwives	80
Naturopathic Physicians	79
Homeopathic Physicians	31
Total Licensed Professionals	87,278

[1] Includes advanced practice nurses.
[2] Licensed by the Dept. of Consumer Protection and the Commission of Pharmacy.

Licensing, however, not only governs minimum competence, it is also a requirement of most insurance policies for service coverage. As such, it represents the financial foundation for health services since 92 percent of Connecticut's population is insured by third-party payers.

Health care facilities. Health care is provided in numerous settings, many of which are licensed by the department. The department licenses health care "institutions", which are defined as hospitals, nursing homes, homes for the aged, health care facilities for the handicapped, home health care agencies, infirmaries, mental health facilities, and facilities engaged in the provision of services for the prevention, diagnosis, treatment or care of human health conditions. With the exception of solo or group physician practices, whose individuals are licensed as health professionals, almost all centers providing health care in the state are required to be licensed.

The department has, through statutory authority and under various regulations, imposed minimum standards to ensure compliance with the public health code as it relates to a facility's operations. The department also conducts periodic inspections to assure code compliance, and investigates complaints against facilities. The following table illustrates the broad range of settings in which health care is delivered throughout the state and numbers of licensed facilities.

Table 37. Licensed Health Care Facilities in Connecticut: 1993

Type of Facility	Number Licensed	Number of Beds
Acute Care Hospitals	35	10,739
Children's Hospitals	1	98
Chronic Disease	6	846
Hospice	1	52
Psychiatric	6	846
Chronic and Convalescent Nursing Homes	226	23,880
Rest Homes	112	5,804
Homes for the Aged	122	3,156
Mental Health Facilities	245	1,714
Other Facilities		
Outpatient Clinics	106	n/a
Ambulatory Surgical Centers	10	n/a
Home Health Care Agencies	55	n/a

Source: Division of Quality Assurance, Department of Health and Addiction Services: 1993.

Health planning. Historically, the department has been involved with health care planning for the state. In the late 1970s and early 1980s the federal government provided

significant funds for health planning activities throughout the nation. Connecticut developed regional health system agencies that served as planning bodies linked to a state-wide health coordinating council under the jurisdiction of the health department. These agencies helped develop a state health plan required for federal funding, and shared responsibility with the Commission on Hospitals and Health Care for deciding capital expenditures for health facilities through the "certificate of need" process.

However, when federal funds ceased in 1985, health systems agencies no longer were able to function. It was also the last year the state produced a health plan and planning activities at the state level ceased.

Recently, under reorganization of the health department, planning has reemerged as a priority. Public Act 93-381 required the agency to develop a state health plan. The department has established a planning unit and intends to hire professionals to staff it.

The Department of Insurance

The Department of Insurance regulates the health insurance industry with regard to the continuing solvency and financial viability of companies providing products in Connecticut. The objective is to protect policyholders from unfair and deceptive practices and to protect individual policyholders from excessive rates. The department licenses companies to sell specific lines of insurance once certain minimum financial and legal standards have been met. No company can offer to sell any health insurance product without first being licensed to do business in the state of Connecticut.

Once a company receives permission from the department to operate in Connecticut, it submits all health policies and contracts for approval prior to offering them to consumers. This includes all indemnity products as well as those provided by health maintenance organizations (HMOs)[17].

Specifically, the Life and Health Division of the department reviews all forms related to individual and group health policies and ensures that the contracts meet all statutory and regulatory requirements. The commissioner does have approval authority on premium rates for individual health plans but not for any group policies. Rating information is not required to be submitted to the department for group policies.

In 1991, the legislature expanded the department's authority over companies providing managed care and utilization review services by insurers and health provider networks. Managed care and utilization review are means for deciding whether care is medically necessary and provided in accordance with professional standards, while encouraging the use of less costly

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[17] Indemnity products are defined as those where a company insures the risk and pays the claims based upon the losses incurred. HMOs are a form of managed care where the company attempts to reduce the amount of losses incurred by taking an active role in claim payments and sharing risk with the providers of health care.

modes of treatment. The department establishes minimum operational standards for companies seeking to perform utilization review and investigates consumer complaints concerning denial of insurance payments for medical coverage. The department may impose civil penalties on companies found violating any statutory and regulatory provisions of the insurance code.

Managed health care and utilization review have emerged as key components of many health insurers' and employers' cost containment efforts. Managed care, along with utilization review, has also been an integral part of most states' health care reform proposals. Both are intended to provide oversight of providers and hospitals by following patients and reviewing the level of services they use.

Currently, there are 305 companies licensed to write health insurance in Connecticut. For 1992, there was a total of $3.543 billion in insurance premiums paid to the 305 companies. Of that, $2.468 billion was for indemnity insurance, while health maintenance organizations accounted for $1.075 billion. The largest single insurer is Blue Cross/Blue Shield of Connecticut with $1.344 billion worth of premiums, accounting for 38 percent of the private health insurance market.

The Department of Social Services

The Department of Social Services is responsible for several major programs that affect Connecticut's health care market. It administers the Medicaid program that supports the medical needs of poor, aged, blind, and disabled individuals who cannot afford care for themselves, and provides medical assistance to indigent people not eligible for Medicaid. The department also sets reimbursement rates for all medical care it provides. Payments to physicians, hospitals, nursing homes, and home health care agencies are part of the department's program. Lastly, the department was recently given "certificate of need authority", which is required for the expansion or construction of nursing homes. This authority had previously resided with the Commission on Hospitals and Health Care.

The department operates one of the largest health insurance plans in the state. It makes payments to nearly 10,000 providers enrolled in the plan who serve approximately 270,000 recipients. For FY 92, medical assistance provided by the department amounted to $1.694 billion.

The Commission on Hospitals and Health Care

The Commission on Hospitals and Health Care is primarily concerned with containing the health care costs associated with Connecticut's 34 acute care hospitals. It has two regulatory tools at its disposal to achieve its mission: the certificate of need process for capital expenditures and new services; and hospital budget and rate review. These two mechanisms form the basis for much of the commission's cost containment efforts.

Connecticut chose to adopt a public utility regulatory model to control health care costs in the early 1970s. While this model had jurisdiction over other sectors of the health care market, its principal authority was over acute care hospitals. A regulatory approach was adopted rather than a market approach because the hospital market was considered to be non-competitive and consumers of health care were not in a position to influence the price or amount of services they were to receive.

Two key features of a competitive market are lacking in the hospital sector: adequate information and knowledge on the part of the consumer to make an informed choice; and the lack of consumer cost incentives given the fact that most services are paid for by a third-party. The demand for hospital care is largely a decision made by a consumer's doctor, not the consumer, and paid for by either the government or an insurer. Most consumers pay little attention to costs when in need of medical care. Moreover, because the public knows relatively little about medicine, health care decisions are entrusted to professionals who have been trained to provide the most appropriate care without regard to costs.

Given the failure of the market place to control for prices and demand of services, states created external regulatory authorities to impose expense and revenue limitations on hospitals. Connecticut followed the direction of several other states when it established the Commission on Hospitals and Health Care.

History of cost containment in Connecticut. Connecticut has a long history of monitoring and seeking to contain health care costs. Beginning in 1949, the Connecticut General Assembly created a hospital cost commission responsible for collecting annual data on medical costs and establishing reimbursable costs for services delivered to public program recipients. A private cost containment project was initiated in 1969 when the Connecticut Hospital Association and Blue Cross jointly formed the Connecticut Hospital Planning Commission, Inc., which reviewed and approved capital expenditures in excess of $150,000. Blue Cross agreed not to reimburse any hospital for a project that was not approved.

In 1969, the legislature created the Council on Hospitals, a joint public/private body. This body was mandated to review capital expenditures in excess of $250,000, study health facility rates, provide cost data to the insurance commissioner, and evaluate charges, reimbursement arrangements, and the quality of health care, but it had no regulatory authority.

In 1973 the legislature created the Commission on Hospitals and Health Care and charged it with the responsibility to control health care costs, improve delivery of health care services, and conduct a continuing state-wide review of health care facility utilization.

Since 1973, the commission has undergone several changes to its statutory mandates including its membership and budget review authority. For a more complete review of the commission's history see Appendix A.

Commission structure, organization and resources. The commission is currently composed of five full-time commissioners appointed by the governor, with the consent of the General Assembly, based upon the following representation:

- a health care professional having both educational and professional experience in the health care field;
- an individual experienced in the field of financial management;
- an individual experienced in the field of hospital and health insurance; and
- two public members.

A chairman and a vice-chairman are appointed by the governor from among the five commissioners for a two-year term.

Table 38. Commission Financial and Staffing Resources.

Fiscal Year	Staff	General Fund Expenditures	Uncompensated Care Pool (staff)	Total Expenditures
1991	47	$2,221,540	n/a	$2,221,540
1992[1]	43	$2,663,413	$12,300,000 (3)	$14,117,409
1993	43	$2,550,127	$3,750,000 (4)	$6,300,127

[1] The increase in Total Expenditures is a result of P.A. 91-2 of the November Special Session, which established an uncompensated care pool funded by assessing all nongovernmental charges by hospitals. The reduction of general fund expenditures in FY 93 reflects the annualization of funding associated with the pools establishment.
Source: Commission on Hospitals and Health Care.

Budget and resources. In FY 91, the commission expended $2,221,540 and employed 44 full-time and 3 part-time staff. The staff is provided through the Department of Health and Addiction Services despite the fact that the commission is an independent agent. Table 38, above shows the financial and staffing resources for the last three fiscal years. The activities of the commission are divided into three functional areas -- research, administration, and operations -- with each being headed by a director.

Passage of Public Act 93-229 changed the method of funding the commission. Instead of receiving state monies the agency is now funded by the hospitals. Each licensed short-term acute care general hospital is allocated a portion of the commission's operating expenses in accordance with each hospital's percentage share of aggregate net revenues.

Scope of regulatory authority. The Commission on Hospitals and Health Care is charged with overseeing the health care delivery system by improving its efficiency and quality, controlling health care costs, coordinating the use of facilities and services, and expanding the

availability of health care throughout the state. To fulfill this mandate, the commission is authorized to:

- review and approve hospital budgets;
- approve hospital rates;
- approve, modify, or deny a Certificate of Need (CON) for any additional function or service proposed by a health care facility or for capital expenditures (except nursing homes, HMOs or home-health care agencies) exceeding $1 million, or $400,000 for buying or leasing equipment;
- administer the uncompensated care pool; and
- conduct a continuing review of health care facility utilization throughout the state.

The commission's budget and rate review process. The commission's major regulatory control over health care costs comes with its authority to review prospectively hospital expenses and revenues. Hospitals historically received payment for services based upon reasonable costs incurred retrospectively. Under this method, hospitals were assured payment for the full costs of caring for patients including direct costs, such as room and board, as well as diagnostic tests, surgical costs, and supplies. Administrative and capital costs were allocated to all patients for such items as physical plant, technology, interest expenses, professional training, and management.

As hospital costs increased beyond the rate of economic growth, changes in the pattern of reimbursement began to take place. In the 1970s as health costs grew, efforts were made to move from retrospective payment systems to prospective payments based upon the amount of resources used for a particular class of illness. Through public utility type regulation, some states began to impose their own limits on the amount of revenue a hospital could receive. The federal government established a system which set the rates it was willing to pay for specific services. Other payers, such as private insurers, have attempted to scrutinize hospital utilization by examining lengths of stay, admission rates, and the use of tests. More recently, health plan providers have begun to negotiate with hospitals to obtain reductions in prices paid for specific services as well as the managing the utilization of those services.

States created regulatory authorities to impose expense and revenue limitations on hospitals because the market failed to control prices and service demand. Connecticut assigned this budget review responsibility to the commission.

The transformation of commission's methodology. The commission's budget and rate review methodology has changed a number of times over the past 20 years. The initial system, in place from 1974 to 1982, provided for detailed budget review of all acute care hospitals and the establishment of rates for routine services. Each year every hospital was reviewed for changes from the previous year's budget. The commission established procedures for reviewing similar categories of hospitals for similar expense areas. All hospitals were given detailed financial examinations irrespective of the size of their projected budget increases. This became a difficult task for the agency to complete within its mandatory April to September time-frame.

During this period the commission decision-making was done by 17 part-time members. To overcome this difficulty, a change in the review methodology was put in place that attempted to focus on hospitals that had extraordinary increases. The part-time commission was also restructured into a full-time three-member body.

From 1983 to 1985, the Commission was required to use a "budget screen" that resulted in the review of only those hospitals seeking increases beyond the rate of inflation plus 2 percent for changes in service volume. The screen used a measure based upon the unit expense per equivalent admission. Hospitals having an increase in this unit measure by less than the rate of inflation plus 2 percent were not subject to detailed review but rather would have their budgets automatically approved.

In 1985 the commission began a transition to a prospective payment system (PPS) for all hospitals in an attempt to introduce the concept of shared financial risk and allow hospitals to retain the economic rewards of cost-effective behavior. As an interim step, detailed budget review was used prior to the full implementation of the prospective payment system in 1986. The PPS system was designed to encourage hospitals to behave more cost efficiently. The intent was to provide incentives to control costs by increasing operational efficiency, eliminate unnecessary services, and to use cost-effective treatment modes.

The PPS system was based upon diagnostically related groups (DRGs) similar to that used for Medicare payments. The underlying principle behind DRGs and prospective payment is that there is an average charge for services rendered given similar categories of illness. The DRGs became the resource unit of measure for setting prices to arrive at a final cost for similar types of illnesses. DRGs represented the volume of services and hospital resources used to treat a particular illness. However, unlike the Medicare prospective payment system, which attempts to set single national rates adjusted for regional differences in labor costs, Connecticut's system developed separate rates calculated for each hospital based upon their total revenue requirements. (Total patient revenue equals price multiplied times DRGs times the number of admissions.) The commission was responsible for establishing a price for each DRG that would fulfill a hospital's need for revenue while at the same time placing limits on expenses.

The prospective payment system ran into several difficulties that made it unmanageable as a rate regulatory mechanism. First, in Connecticut, because each hospital had its own set of prices that were applied to DRGs, the commission had focused on price increases rather than on comparisons among hospital payments for similar services. The federal Medicare PPS is intended to provide similar payments for similar hospital stays, but Connecticut lacks a single payer which resulted in different DRG payments being made throughout the system. Confidence in the system was further undermined by the number of adjustments that had to be made to make PPS work properly. While PPS and DRGs were expected to bring rationality to hospital pricing, just the opposite occurred in Connecticut as the system became increasingly complex and difficult to administer.

The severest criticism of the system came from consumers who were forced to pay for costs they did not incur. All payers were expected to pay the average charges even if the incurred costs were less than the average. In the long run, the costs would average out so a single large payer would not be disadvantaged by paying charges that were greater than costs. However, this did not work well for individuals who had some responsibility for paying their own bills.[18] The DRG system was really meant to apply to a single payer who could withstand some charges below the average and some above the average. It was not meant to apply to individuals who would never be able to take advantage of averaging a large number of hospital stays.

The PPS system was replaced in 1990 by a prospective budget review process that included exemptions from any review, partial review of some costs, and detailed budget reviews for hospitals. This is the system currently in place, though the 1992 session of the General Assembly instituted a temporary suspension of the budget review process by establishing, for one year, maximum allowable budget increases.

For 1993, the budget process negotiated in the legislature granted hospitals a 4.25 percent increase for gross revenue and 3.25 percent increase for net revenue. Hospitals that exceeded the commission authorized budget cap in FY 90 were allowed to keep the excess revenue. Excess revenue taken by hospitals in 1992 was also allowed to the extent that the additional revenue would be subtracted from a hospital's increase, but no hospital would receive a budget decrease as a result of not complying with the commission's authorized budget caps.

The current budget and rate review mechanism. As noted earlier, the Commission on Hospitals and Health Care has the power to approve, deny, or modify a hospital's budget prior to its implementation. In addition to this broad regulatory power, the commission also has the authority to approve certain rate increases for per diem patient room rates and aggregate rates for special services, as well as price lists for specific goods and services.

The commission has specific authority to examine revenues and expenses for each hospital. Hospitals are subject to three levels of review: 1) detailed examination of all financial activities; 2) partial review of specific costs; and 3) exemption from review if the hospital's budget increases meet certain statutory screens on revenues, expenses, and the number of patient discharges. Hospitals meeting the exemption requirements, to be described shortly, were not subject to detailed budget review.

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[18] For instance, if you only spent two days in the hospital but the average DRG called for four days, you were then billed for four days. For payers with a large number of patients the average charges would equal the average costs incurred, over the long run, but for individuals required to bear the immediate costs for a specific incidence of hospitalization, paying for charges greater than the costs incurred was a onerous burden. Patients who were required to pay a portion of their hospital bills became upset upon learning they would have to pay for days in the hospital they did not stay.

A hospital's budget is set by the commission based upon three separate financial measures: gross revenue; net revenue; and net expenses. Each of these measures is computed by the commission and represents a hospital's authorized budget for a given fiscal year. Each financial measure has its own formula and adjustments for determining the year-to-year increase. They can be defined as follows:

- Gross revenue is the amount of money a hospital would receive if everyone paid the same for services received. Some patients do not pay for their services, with the bill covered as charity care or bad debt, while others pay only a portion of established charges normally billed to most patients, such as Medicare and Medicaid;

- Net revenue is defined as the actual revenue received by hospitals on behalf of all patients; and

- Net expenses are the costs of treating and caring for patients minus recovered expenses such as research grants, parking fees, and cafeterias where a hospital generates income to offset costs.

To determine revenues and expenses, the commission begins with a base year budget and adds the rate of inflation plus two percent to each of the three measures: gross revenue; net revenue; and net expenses. Added to each are two additional adjustment factors: 1) the unauthorized (by the commission) increase or decrease in last year's budget due to changes in the level and volume of services (at a rate of 50 percent of the actual amount); and 2) any future increases or decreases in the estimated number of discharges expected for the future budget year. A hospital's budget is built upon the general formula outlined in the Table 39 entitled "Budget Review Methodology".

In theory, a hospital's budget is composed of the price of its services times the amount of services provided. It is important to understand that not only are price increases a factor but the volume of services consumed represents a significant variable in the cost equation. The table above illustrates the various formulas used to determine the financial condition of hospitals.

The budget caps for gross revenue, net revenue, and net expenses are actually computed by taking the average per patient revenues and expenses for the base year and multiplying it by the number of projected discharges, as noted above. The product of these numbers creates the total net budget expense and revenue figures for the hospital. These figures are then multiplied by the rate of inflation plus two percent to arrive at the prospective year's budget. Projected discharges are based upon a three-year average increase of actual patients, adjusted for the variable cost of providing care. If a hospital went over its previously approved budget, the commission would obtain compliance by subtracting that amount from the subsequent budget year. Thus a hospital's budget increase is reduced by the amount of money owed from exceeding a previous budget authorization.

Table 39. Budget Review Methodology

General Theory

Revenue = Price times Volume

Hospital Budget = the Volume of Services times the Average Price for the Services.

Specific Budget Caps

Gross Revenue =
Projected Equivalent Discharges (Inpatient/Outpatient) X Average Gross Revenue (Base Year)
X Inflation Plus 2% - Compliance

Net Revenue =
Projected Equivalent Discharges (Inpatient/Outpatient) X Average Net Revenue (Base Year)
X Inflation Plus 2% - Compliance

Net Expenses =
Projected Equivalent Discharges (Inpatient/Outpatient) X Average Net Expense (Base Year) X Inflation Plus 2%

If a hospital's budget meets all three caps then its is not subject to detailed budget review.

Three specific cost screens emerge from the computation of the above formulas: 1) net annual average revenue per equivalent discharge; 2) net annual budgeted expense per equivalent discharge; and 3) a gross revenue per equivalent discharge. Each of these measures is used to determine a cap on the dollars to be spent by a hospital based upon the number of patients served. These unit cost screens are designed to determine the level of regulatory scrutiny hospitals will be placed under. The screens are: 1) exemption from budget review; 2) partial budget review; or 3) detailed budget review. These three levels of review, along with cost measures, form the basis for Connecticut's health care cost containment system.

Budget review choices. If a hospital meets all three cost screens by not increasing its net revenues, net expenses, and gross revenues by more than inflation plus two percent, plus an adjustment for volume, then it is exempt from further budget review though required to submit detailed budget information. The commission continues to provide oversight of the hospital actual expenses and revenues to assure compliance with its budgetary limits.

If a hospital meets the cost screens but seeks additional revenue it can do so through partial review of costs. The increases sought must be attributed to one of the following four factors: 1) increases in malpractice insurance; 2) changes in the hospital's mix of patients -- presumably having to serve sicker cases requiring greater resources; 3) changes in the payer mix that could require a shifting of costs, such as having to provide more free or uncompensated care; or 4) costs associated with a commission-approved "certificate of need" for a large capital

expenditure requiring additional future funds. A hospital may seek additional budget authorization if it can prove to the commission that any of these factors require it to spend more money.

A hospital not meeting the cost screens or not meeting one of the four criteria for partial budget review is subject to detailed review by the commission. The hospital's budget is reviewed by a panel of two or three commissioners who ultimately report findings to the full commission. The panel will frequently hold public hearings and seek information from staff, the hospitals, and interested parties. Detailed budget reviews are based upon "presumptively reasonable tests", (standardized measures for increases) for financial cost centers within the hospital. Frequently, a hospital's budget is subject to negotiation between commission members and hospital administrators who must justify their cost projections in order to obtain approval.

Hospitals are further required to meet the budget exemption screen, inflation plus two percent on revenues and expenses, at least once every three years, and also are subject to detailed budget review within the same three-year period. This requires hospitals to live within the revenue and expense caps, but also insures detailed review of hospital budgets on a regular basis.

Table 40. The Application of Hospital Budget Review Methods: FY 92 & FY 93

Type	Hospitals	Gross Revenue Per Discharge	Net Revenue Per Discharge	Percentage Increase Without Compliance	Percentage Increase With Compliance
For FY 92					
Partial	13	9,900	6,960	9.06%	8.55%
Exempt	6	9,494	6,134	6.67%	5.48%
Detailed	15	8,270	5,751	9.03%	9.57%
For FY 93					
Partial	2	12,527	7,538	6.73%	6.16%
Exempt	27	9,612	6,560	6.82%	5.14%
Detailed	5	8,824	5,889	6.78%	4.23%

Source: CHHC Decision Database. (Unweighted averages).

Hospital increases. Table 40 displays the actions taken by the Commission on Hospitals and Health Care in 1991 and 1993 on hospital budgets. The table classifies hospitals by the type

of review used and the average increases for each. These averages are not weighted by the size of a hospital's budget which would yield slightly different numbers.

If hospital budgets are weighted for size, the aggregate averages for commission authorized price increases were 11.19 percent for FY 91, 8.7 percent for FY 92, and 7.67 percent for FY 93. Comparisons with years prior to 1991 are difficult due to the differences in the budget review methods.

Certificate of need. The second major regulatory tool used by the commission is the "certificate of need" process. This mechanism is used to limit the expansion of unnecessary technology and health care facility capacity.

A certificate of need (CON) is a statement issued by a state agency containing the state's formal acknowledgment that a health care facility, medical equipment acquisition, or new medical service is needed. The fundamental assumption behind the CON program is that because the medical marketplace is unique, normal market competition results in unnecessary expenditures on facilities and equipment rather than a reduction in prices. Because the medical market place is imperfect, increased competition in health care does not always result in a corresponding decrease in charges because oversupply of beds and equipment has a tendency to create demand. Thus, it is contended that supply must be regulated to contain utilization and cost. By limiting the growth of health care programs, equipment and facilities, through a state approval process, it is argued that excess expenditures are prevented.

The development of the CON program. The United States Congress through the National Health Planning and Resources Development Act (Public Law 93-641) of 1974 provided substantial funding for state and local health planning activities and required all states to create a CON program by 1980. The purpose of the act was to contain health care costs by strengthening states' health planning functions and by regulating capital expenditures, acquisition of major medical equipment, and expansion of new functions or services by health care institutions.

The federal law required a state agency to make written findings as to the community need for the project, financial feasibility, expected quality of care, less costly alternatives, and accessibility of the project to undeserved populations.

There was clearly no uniformity among the states in implementing the federal law. Most adopted CON legislation by 1980, but few fully complied with the prescriptions in the federal act. In the early 1980s under the Reagan Administration's emphasis on deregulation, commitment to national health planning began to deteriorate. By 1986, federal funding had disappeared and the federal health planning act was repealed.

Critics of CON programs maintain they discourage the entry of new providers, which give, in effect, franchise protection to existing providers and therefore limit competition and restrain price pressures. As a result, states have begun to diversify program structures and

review requirements. The trend over the second half of the 1980s was generally to reduce the scope of CON primarily by raising thresholds, streamlining review procedures, and eliminating some services from the domain of CON. Traditionally, states with strong rate regulation programs have not relaxed review requirements to the same degree.

Over the past couple of years however, as health care costs continue to rise, states are reestablishing or strengthening their CON programs. Although no longer federally mandated, many states have shown renewed interest in CON as a mechanism to control mounting health care costs by preventing the development of duplicative, unneeded health facilities, or the introduction of unneeded services. Deregulation has increasingly been blamed for unnecessary construction, duplication of services, overuse of high technology and decreasing access to primary care services. Furthermore, increased attention to health planning has emerged as states enact health care reform measures to control costs while expanding coverage to the medically underserved. As a result, the movement to strengthen CON and health planning has been gathering momentum.

Other state CON programs. Currently 38 states and the District of Columbia operate CON programs. Table 41 presents individual state thresholds for capital and equipment expenditures, and the type of new services that must undergo review. As the table shows, there is wide variation among states, with some states exempting hospitals and other specific types of facilities or services from reviews while others are more comprehensive in their CON programs.

Connecticut's certificate of need program. Connecticut established its CON program in 1973 along with the commission. Under the program, as it currently exists, CHHC is statutorily mandated to review and approve the following:

- capital expenditures of most health care facilities exceeding $1 million;
- acquisition of major medical equipment by health care facilities requiring a capital expenditure in excess of $400,000;
- acquisition by any person of imaging equipment costing more than $400,000;
- a facility or institution intending to introduce any new or additional function or service, or increase its staff; and
- a facility or institution intending to terminate a health service or decrease substantially its total bed capacity.

Health maintenance organizations and home-health care agencies are not required to obtain a CON for capital expenditures or for introduction of additional services. In addition, the responsibility for CON review for long-term care facilities, such as nursing homes, was transferred to the Department of Social Services under Public Act 93-262.

Figure 5 shows the certificate of need process. The first step begins when the applicant submits a letter of intent to the commission. The letter of intent provides notification to the commission that the applicant plans to submit a CON application and must contain:

TABLE 41. CON REVIEW THRESHOLDS

	CAPITAL	EQUIPMENT	NEW SERVICE
Alabama	$1,500,000	$ 500,000	Any
Alaska[1]	$1,000,000	$1,000,000	$1,000,000
Arizona			
Arkansas[2]	Any LTC		Any LTC
California			
Colorado			
Connecticut	$1,000,000	$ 400,000	Any
Delaware[3]	$ 750,000	$ 750,000	$ 250,000[4]
Dist. of Columbia	$ 600,000	$ 400,000	$ 250,000[4]
Florida[5]	1,000,000	$1,000,000	Any, with exemptions
Georgia[6]	$ 866,896	$ 485,819	Specified services
Hawaii	$4,000,000	$1,000,000	Specified services
Idaho			
Illinois	$2,000,000	$1,000,000	Specified services
Indiana[7]	Any LTC		Any LTC
Iowa	$ 600,000	$ 400,000	$ 250,000[8]
Kansas			
Kentucky	$1,500,000	$1,500,000	$ 600,000 for specified services
Louisiana[9]			
Maine[10]	$1,000,000-Hosp	$1,000,000-Hosp	$ 155,000[10]
	$ 500,000-LTC	$ 300,000-LTC	
	$ 350,000-Other	$ 300,000-Other	
Maryland	$1,250,000		Specified services
Massachusetts[11]	$7,500,000-Acute	Any-Acute	Specified Services
	$ 800,000-Other	$ 400,000-Other	
Michigan	$ 750,000	$ 750,000	$ 750,000
Minnesota			
Mississippi	$1,000,000	$1,000,000	Specified services
Missouri	$ 600,000	$ 400,000	Any[12]
Montana[13]	$1,500,000	$ 750,000	$ 150,000 with exemptions
Nebraska	$1,216,800	$ 912,600	$ 557,700/760,000[14]
Nevada[15]	$4,000,000	$1,000,000	Specified services
New Hampshire[16]	$1,000,000	$ 400,000	Specified services
New Jersey	$ 600,000	$ 400,000	Any
New Mexico			
New York[17]	$ 400,000	$ 400,000	$ 400,000
North Carolina	$2,000,000	$2,000,000	$1,000,000,[4] plus specified services
North Dakota	$ 750,000	$ 500,000	$ 300,000[18]
Ohio	$2,000,000	$1,000,000	$ 750,000
Oklahoma[19]	$ 500,000		Any with beds
Oregon[20]	Variable	$1,000,000	$ 500,000
Pennsylvania	$2,000,000	$ 400,000	Any $316,873 AOE, plus specified services
Rhode Island[21]	$ 600,000	$ 400,000	$ 250,000[4]
South Carolina	$1,000,000	$ 600,000	$ 400,000[22]
South Dakota			
Tennessee	$2,000,000	$2,000,000	Any with beds
Texas			
Utah			
Vermont	$ 300,000	$ 250,000	$ 150,000[4]
Virginia	$ 700,000	$ 400,000	$ 400,000[23] for specified services
Washington[24]	$1,202,000		Specified services
West Virginia	$1,000,000	$ 750,000	$ 500,000,[4] plus specified services
Wisconsin[7]	Any LTC		Any LTC
Wyoming			

Source: American Health Planning Association, July 25, 1990;
updated by Alpha Center, November 1990, and Lewin-ICF, March 1992.

1. Alaska reviews all expenditures relating to additions of a major type, unit, program, division or department of care for which the total of the associated annual operating costs and capital costs exceeds $1,000,000.

2. Arkansas replaced its CON program with a "permit of approval" program which reviews nursing homes, home health services and residential care facilities only.

3. Delaware also reviews all new facilities and changes in bed capacity which increase or decrease the number of beds by more than ten or ten percent within a two-year period.

4. Threshold refers to annual operating expenses.

5. Florida also reviews all new facilities and changes in licensed bed capacity.

6. Georgia also reviews any addition of beds.

7. Indiana and Wisconsin review nursing homes only.

8. Iowa reviews all new services for which the total of the associated capital and operating expenses exceeds $250,000.

9. Louisiana does not have a state CON statute, but withholds state Medicaid capital reimbursement from disapproved projects.

10. Maine reviews new services with third year operating costs exceeding $155,000.

11. Massachusetts uses different thresholds for acute and nonacute care facilities. Additional places of previously approved equipment may be added by a facility without CON review.

12. Missouri reviews all new services for which the associated capital or equipment costs exceed designated thresholds.

13. Montana no longer has coverage by type of facility. Rather, it reviews ambulatory surgery, home health, long term care, inpatient psychiatric and substance abuse treatment, rehabilitation, and personal care services.

14. Nebraska reviews new services with annual operating expenses exceeding $557,700 and substantial changes to existing services with annual operating expenses exceeding $760,000.

15. Nevada also reviews any addition of acute or long term care beds.

16. New Hampshire conducts a full CON review of specified services regardless of cost of project, and an administrative review of certain other specified services regardless of cost.

17. New York conducts an administrative review of expenditures between $400,000 and $4,000,000. New York conducts a full CON review of expenditures exceeding $4,000,000, any addition of beds, expenditures exceeding one percent of the facility's annual operating budget, and specified services regardless of cost.

18. North Dakota reviews any new or expanded services with annual operating expenditures exceeding $300,000 that involve a capital expenditure of any amount.

19. Oklahoma reviews only licensed nursing facilities and psychiatric or chemical dependency services, unit or facilities.

20. Oregon reviews capital expenditures of any amount for new hospitals and new hospital services with annual operating expenses in excess of $500,000. All new long term care facilities of services which increase bed capacity by more than 10% or 10 beds, whichever is less, within a two-year period are also subject to review.

21. Rhode Island also reviews all bed additions for inpatient care and all additions in the units of outpatient services (e.g. the number of patients that can participate in a substance abuse treatment program).

22. South Carolina also reviews new services for which there are criteria specified in the state health plan that do not involve a capital expenditure and which have annual operating costs exceeding $400,000.

23. Virginia deregulated selected types of major medical equipment and certain clinical services in 1989. Deregulation of general hospitals and ambulatory surgery centers is set for July 1, 1991.

24. Washington reviews capital expenditures exceeding $1,202,000 for nursing homes only. Washington also reviews the establishment of all new facilities and changes in bed capacity.

- the applicant's name;
- a statement indicating the type of project;
- the estimated capital cost;
- the location of the project; and
- a brief project description.

The letter of intent must be on file at the commission for at least 90 days but no more than 120 days before a CON application can be submitted and considered filed. The time requirement may be waived if the proposal is necessary to comply with health, fire, building, or safety codes.

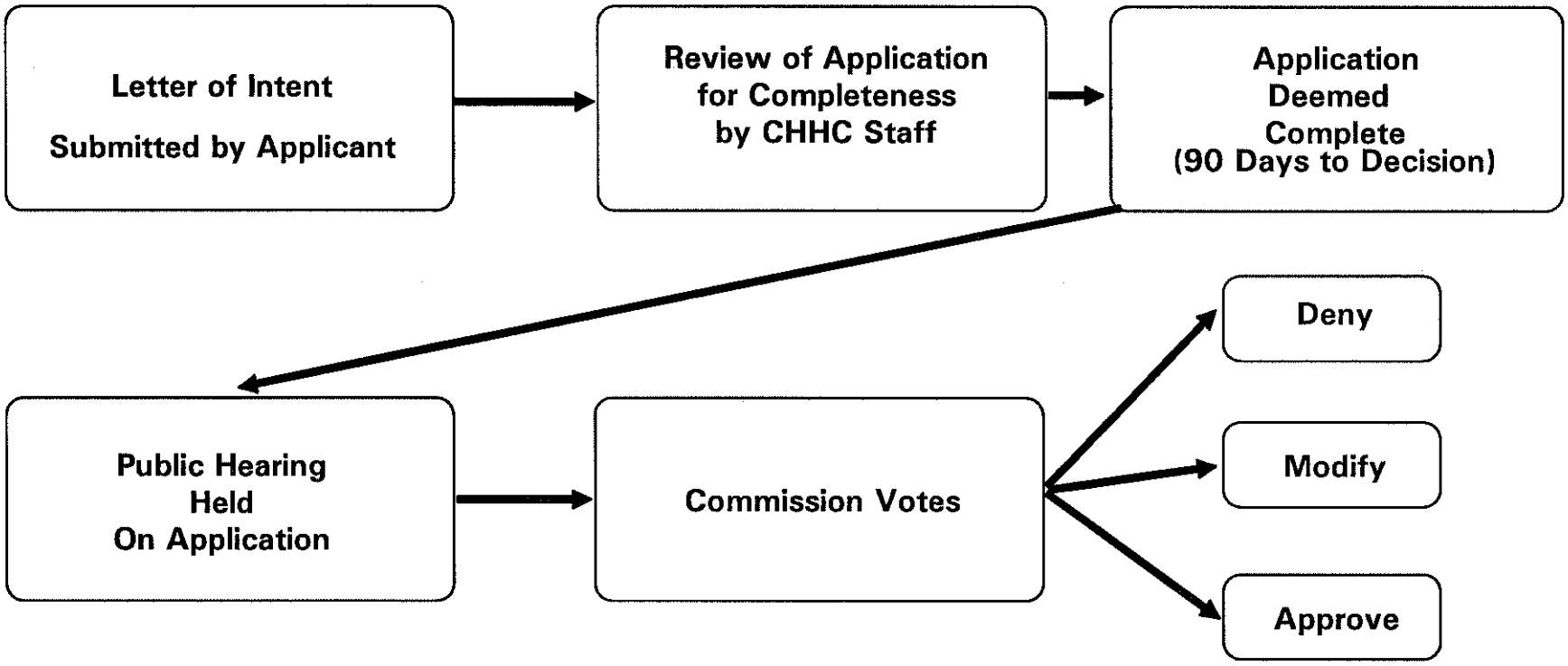
Time frame for review. Once an application is determined to be complete, the commission has 90 days to review and issue a decision on a CON application, unless certain time extensions are granted. The review time period does not apply if the application is from a short-term general hospital or children's hospital whose projects require a future budget adjustment.

Review criteria. During the review period, the commission is required to consider several criteria when evaluating CON applications, and in most cases, hold a public hearing on the application. Specifically, the commission must make written findings on:

- the relationship of the proposal to the state health plan and the applicant's long-range plan;
- the financial feasibility of the proposal and its impact on the applicant's rates and financial condition;
- the impact on the interests of consumers and payers for such services;
- the contribution of such proposal to the quality, accessibility, and cost-effectiveness of health care delivery in the region and public need;
- competence of facility managers;
- sufficiency of rates;
- changes to the applicant's current utilization statistics;
- teaching and research responsibilities; and
- patient-physician mix characteristics;

Public hearing. Public hearings on certificate of need applications are generally held half-way through the 90-day CON application process. Commission staff provide the applicant with an "issues paper", which defines the main areas for discussion at the public hearing. At the time of the public hearing, interested parties may be given party or intervenor status by the hearing officer (a presiding commissioner). Public Act 93-381 gives the commissioner of the Department of Public Health and Addiction Services the power to appear and participate as an intervenor in any hearing or proceeding concerning CON for the purposes of determining compliance with the state health plan. However, development of the state health plan is still in the initial stages.

Figure 5: Certificate of Need Process



Thresholds

Capital Expenditures > $1 Million
Medical Equipment > $400,000
New or Additional Service

Termination of Health Service
Substantial Decrease of Bed Capacity

Issuance of decision. The commission may grant, modify, or deny a CON application. A quorum of commissioners (three) must be present to vote and render a decision. Most commission decisions involve a modification of a CON application, known as an "agreed settlement", which is a negotiated document between the applicant and the commission. The agreed settlement may involve modification of items contained in the CON application, and may include items not contained in the original CON application.

Under Public Act 93-381, the commission, whenever granting, modifying, or denying a CON request regarding services that are inconsistent with the state health plan, is required to issue a written explanation of the reasons for the inconsistency when issuing its decision.

Analysis of CON Decisions. Program review committee staff analyzed two years of commission decisions for certificates of need. Table 42 shows the number of CON applications submitted and type of decisions issued for calendar years 1991 and 1992 for all proposals. Decisions under the approved column in the table include those that resulted in an agreed settlement, while those in the modified column indicate that the applicant requested a modification in a previously approved CON. An analysis of CON decisions shows that for both calendar years reviewed, few applications are denied by the commission -- 12 percent in 1991 and only 2 percent in 1992. The vast majority of applications are approved with 74 percent approved by the commission in 1991 and an overwhelming 91 percent in 1992. When modified CONs are included in the commission decisions approval rate, the percentage increases significantly to 88 percent and 98 percent respectively.

Table 42. Certificate of Need Decisions for Calendar Years 1991 and 1992.

Type of Certificate of Need Decision	Approved	Modified	Denied	TOTAL
1991	134	25	21	180
1992	120	9	3	132

Source: CHHC Decision Database.

Program review committee staff found that not all CONs submitted for review to the commission had a cost attached. Of the total 180 CONs reviewed by the commission in 1991 and 132 CONs in 1992, 48 percent and 46 percent respectively involved implementation costs. Table 43 shows the number of CONs with costs attached that were approved, modified, or denied. In 1992, an overwhelming number (88 percent) was approved, while only a fraction (3 percent) was denied by the commission.

The total costs of CON requests for two years were compared to those finally approved by the commission. Table 44 presents the information for all CONs reviewed by the commission (approved, modified, or denied). As the table indicates, the CONs that were approved by the commission represent a majority of costs initially requested by applicants. For

example, in 1992, the commission reduced the overall aggregated costs of CONs by $20,652,890 but still approved 92% of the requested total CON costs.

Table 43. Certificate of Need Decisions Involving Costs.

Calendar Year	Total CONs involving Cost	Number Approved (%)	Number Modified (%)	Number Denied (%)
1991	86	58 (67%)	17 (20%)	11 (13%)
1992	60	53 (88%)	5 (8%)	2 (3%)

Source: CHHC Decision Database.

Table 44. Aggregated Requested and Approved Costs of CONs for Two Calendar Years.

Calendar Year	Aggregated CON Requested Cost	Aggregated CON Cost as Approved	Difference	% of Total Requested Dollars Approved
1991	$525,732,298	$436,207,282	$89,525,016	83%
1992	$259,245,236	$238,592,346	$20,652,890	92%

Source: CHHC Decision Database.

Health Planning in Connecticut. The CON program has three, often competing, goals: quality, accessibility, and cost. However, in the absence of a state health plan that describes goals and objectives, specifies priorities, and integrates the many competing facets of the health care delivery system, the certificate of need process cannot be effective. State efforts in comprehensive health planning collapsed in 1985 with the demise of federal funding and the repeal of the national health planning act. The lack of a state health plan has made it difficult, if not impossible, to decide on the allocation of scarce resources. An overall picture of the resources that exist in the health care delivery system today is absent.

As a result of Public Act 93-381, current efforts are underway to establish a health planning unit in the Department of Public Health and Addiction Services. The act designated the department as the lead state agency for public health planning and directed it to prepare a multi-year state health plan and assess Connecticut residents' health and access to services and facilities.

Health planning in a competitive market should act as a constraint on competitors by setting minimum standards of service to ensure quality and specify maximum investments in certain technologies or capacities to serve the population. A comprehensive health plan is one

that measures and forecasts short- and long-term demand, evaluates existing programs, and analyzes trends, and will ultimately aid in identifying the type, location, and number of future health care facilities and services that are needed. Without an overall framework in which to guide decision-making, the goals of the state in allocating resources, insuring access, and containing costs will be difficult to meet.

CHAPTER V: FINDINGS AND RECOMMENDATIONS
PROBLEMS WITH CONNECTICUT'S COST CONTAINMENT SYSTEM

The Commission on Hospitals and Health Care's regulatory authority extends only to a small percentage of total health care costs in Connecticut. For 1991, total inpatient hospital net revenues were $3.1 billion, 24 percent of the total health related expenditure of $12.75 billion. The commission's control over health care costs through hospital budgets is furthered limited by its lack of influence on several payers who account for a large share of total spending. As the following table indicates, government payers and HMOs represent 53 percent of hospital revenue. These two payers are able to set their own prices for hospital services.

The commission does not have control over the payments set by the federal government for Medicare and CHAMPUS (Civilian Health and Medical Program for Uniformed Services), and the state sets the reimbursement levels for Medicaid. In addition, HMOs are allowed to negotiate with hospitals payments they make for services. This leaves approximately $1.578 billion directly regulated by the state, which represent only 12.3 percent of the state's spending on health care.

Table 45. Hospital Revenues By Source of Payment: Fiscal Year 1991-1992.

Payer	Amount	% of Total
Blue Cross	**$511**	**15.29%**
HMOs	$299	8.95%
Commercial Insurance	**$860**	**25.73%**
Other Payments	**$207**	**6.21%**
Medicare	$1,179	35.25%
Medicaid	$278	8.33%
CHAMPUS (Federal Employees)	$8	.24%
Total	$3,345	100%

Bolded are those who must pay commission approved charges.
Source: Commission on Hospitals and Health Care, August 18, 1993.

Factors influencing health care costs. Two key features of a competitive market are missing in the hospital sector. One is the lack of adequate information, knowledge, and expertise on the part of the consumer to make an informed choice and, two is the lack of cost incentives because most hospital services are paid for by a third party. The demand for hospital care is largely a decision made by a physician not the patient and paid for by either the government or an insurer. Most consumers pay little attention to costs when in need of hospital

care. Moreover, because the public knows relatively little about medicine, health care decisions are entrusted to professionals who have been trained to provide the most appropriate care without regard to costs.

Connecticut's high level of income also has a direct relationship to its health care costs. When measured against income, Connecticut's hospital costs are not nearly as high as other states and the rest of the nation. In 1992, the state's per capita income was $27,137 compared to the rest of the nation at $19,330. Connecticut's per capita hospital costs as a percent of personal income was much below the national average. Nationally, hospital costs average 5.08 percent of income, while in Connecticut the percentage of income spent on hospital care was only 3.95 percent. Part of the difficulty with containing costs in Connecticut lies in the fact it has the highest per capita income in the nation.

In a study of the relationship between health care expenditures in other countries and their levels of income, the conclusion was that income was the most important determinant of the level of expenditure. The study found that over 90 percent of variance among countries could be explained by the level of wealth[19]. This points out two important factors concerning health care. First, health care becomes an increasingly important consumer preference as wealth rises and second, given that health care is a staff intensive service, generally higher incomes have a significant impact on health expenditures.

Regulating hospital costs. While the commission's activities have resulted in diminishing the increases in hospital revenues -- Connecticut's percentage increase in expense per admission was below the national average in 7 out of 11 years[20] -- the process has also supported a great range in price levels that would not exist in a competitive market. As a result of the regulatory process, hospital rates have exhibited a wide range in charges for specific services as well as average hospital charges.

Table 46 shows a composite charge defined as the average net revenue (actual revenue received from payers) for a patient day (adjusted for differences in the severity of patients treated). The range for this measure is from $763 to $1,144. Fifteen hospitals are above the state average by as much as 25 percent. There is also a 42 percent difference between the highest and lowest hospital.

Even greater variation exists among hospitals on a revenue per discharge basis defined as the average cost of a patient stay in the hospital adjusted to account for differences in the illness severity. In Table 47, net revenue per discharge shows a range from $4,552 to $7,185.

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[19] William J. Moore, et. al., *Measuring the Relationship between Income and National Health Expenditures*, Health Care Financing Review, Fall 1992, pp. 133-139.

[20] See *Containing Health Care Costs in Connecticut*, Table 10, page 34.

The nature of the budget and rate review process provides hospitals with a strong incentive to increase cost, which is tied to revenues and charges. Hospitals have been faced with a regulatory system that requires them to seek the largest budget possible from the Commission on Hospitals and Health Care with little or no incentive to come before the agency with efficiencies that could lead to cost reductions and thus reduced budgets. The system freezes inefficiencies in place and may even result in widening disparities in charges as hospital budget-making tends to be based upon percentage increases from the previous year's revenues.

Once a hospital's budget is approved, payers are required to pay the charges that result from the approved budgets. There are, however, two groups that are allowed to deviate from the commission imposed charges; government payers who set their own rates; and health maintenance organizations who have the statutory authority to negotiate with hospitals over charges to their members.

Table 46. Net Patient Revenue Per Case Mix Adjusted Equivalent Patient Day (NPR/CMA-EPD) FY 1992

Hospital	Size	NPR/CMAEPD	% Deviation From Mean
PARK CITY	C	$1,144	125%
NEW MILFORD	D	$1,096	120%
ROCKVILLE	D	$1,093	120%
STAMFORD	B	$1,070	117%
DAY KIMBALL	C	$1,053	115%
YALE-NEW HAVEN	A	$1,051	115%
MILFORD	D	$1,014	111%
NORWALK	B	$1,006	110%
MOUNT SINAI	B	$983	108%
GREENWICH	C	$962	105%
VETERANS MEMORIAL	C	$962	105%
SHARON	D	$951	104%
WINSTED	D	$948	104%
WATERBURY	B	$938	103%
ST JOSEPH	C	$931	102%
DANBURY	B	$921	101%
WINDHAM	C	$906	99%

Table 46. Net Patient Revenue Per Case Mix Adjusted Equivalent Patient Day (NPR/CMA-EPD) FY 1992			
Hospital	Size	NPR/CMAEPD	% Deviation From Mean
GRIFFIN	C	$898	98%
MIDDLESEX	B	$884	97%
HARTFORD	A	$870	95%
MANCHESTER	C	$857	94%
NEW BRITAIN	B	$845	92%
ST MARY	B	$835	91%
LAWRENCE & MEMORIAL	B	$828	91%
CHARLOTTE HUNGERFORD	C	$816	89%
BRISTOL	C	$814	89%
JOHNSON MEMORIAL	D	$809	89%
ST VINCENT	B	$801	88%
ST FRANCES	A	$792	87%
BRIDGEPORT	A	$788	86%
BRADLEY	D	$767	84%
BACKUS	C	$766	84%
ST RAPHAELS	A	$763	83%
STATE AVERAGE		$914	100%

Table 47. Net Patient Revenue Per Case Mix Adjusted Equivalent Discharge (NPR/CMAED) FY 1992			
Hospital	Size	NPR/CMAED	% Deviation From Mean
YALE-NEW HAVEN	A	$7,185	125%
NORWALK	B	$7,016	122%
ST JOSEPH	C	$7,002	121%
STAMFORD	B	$6,696	116%
PARK CITY	C	$6,658	115%
MOUNT SINAI	B	$6,472	112%
WATERBURY	B	$6,427	111%

Table 47. Net Patient Revenue Per Case Mix Adjusted Equivalent Discharge (NPR/CMAED) FY 1992			
Hospital	Size	NPR/CMAED	% Deviation From Mean
ST RAPHAELS	A	$6,160	107%
GREENWICH	C	$6,073	105%
GRIFFIN	C	$6,043	105%
DANBURY	B	$5,929	103%
SHARON	D	$5,895	102%
HARTFORD	A	$5,871	102%
BRIDGEPORT	A	$5,862	102%
MILFORD	D	$5,846	101%
JOHNSON MEMORIAL	D	$5,763	100%
WINSTED	D	$5,688	99%
VETERANS MEMORIAL	C	$5,642	98%
ST VINCENT	B	$5,637	98%
ST MARY	B	$5,549	96%
CHARLOTTE HUNGERFORD	C	$5,441	94%
DAY KIMBALL	C	$5,368	93%
NEW MILFORD	D	$5,365	93%
WINDHAM	C	$5,350	93%
ST FRANCES	A	$5,241	91%
LAWRENCE & MEMORIAL	B	$5,125	89%
BRADLEY	D	$5,123	89%
MIDDLESEX	B	$5,116	89%
ROCKVILLE	D	$5,094	88%
NEW BRITAIN	B	$5,075	88%
MANCHESTER	C	$5,040	87%
BRISTOL	C	$4,974	86%
BACKUS	C	$4,552	79%
STATE AVERAGE		$5,766	100%

Large price differences would not exist in a normally competitive market. Because Connecticut's regulatory system allows for very limited price negotiation among the various payers, more costly hospitals are able to retain market share rather than being forced to equalize prices as a result of competition.

The regulatory system has also not been able to reduce hospital capacity in Connecticut. Hospitals in Connecticut have excess capacity for inpatient services. Table 47 shows that the average occupancy rate for staffed beds was 73.3 percent. Two-thirds of the hospitals listed fall below 80 percent capacity indicating there is currently excess capacity in the system. (When licensed beds[21] are considered the rate of utilization is even lower. For instance, both Rockville and Mount Sinai have high rates of utilization for staffed beds, but have very low rates, 53.8 and 42.3 percent respectively, for licensed beds.) Neither the budget review process nor the certificate-of-need process has been able to reduce this excess capacity.

As noted in the program review committee's briefing paper, a recent study[22] for the Commission on Hospitals and Health Care found that hospitals, by 1997, will have 2,877 excess licensed beds and 883 excess staffed beds. If the consultant estimates are correct, hospital utilization in Connecticut would then drop to 39 percent based upon projected need. The combination of fewer patients and days in the hospital has forced the rate of capacity utilization down. Excess bed capacity in the hospital system leads to excess overhead costs. Hospitals competing for patients based upon price and utilization will have a greater incentive to reduce bed capacity than in the current regulatory system.

Hospitals operating in a competitive market place are being forced to adopt efficiencies as health plans seek to contain costs. Health plans, through managed care, utilization review, and price negotiation, have limited hospital revenues by requiring enrollees to use providers willing to accept cost containment measures. Competing health plans form a powerful incentive to allocate hospital resources in an effective manner.

Certificate of Need. Advocates of certificate of need programs argue that because the health care market is imperfect, a certificate of need process is necessary to limit excess expenditures on medical technology and unnecessary capital investment. Proponents claim that CON laws serve an important "gatekeeping" function due to the complex time-consuming nature of the process and the intensity of the review. For this reason, the process deters some from filing an application and causes others to withdraw applications during the approval process. Thus, by acting as a gatekeeper, costs are contained and certificate of need applications are restricted.

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[21] Licensed beds are the number of authorized beds that a hospital may have, though the beds may not be physically present. Staffed beds are those which are physically present and are intended to be used.

[22] *Assessment of Current Health Care Facilities and Future Requirements,* Arthur D. Little, Inc., June 11, 1993.

Alternatively, critics argue there are a number of hidden costs imposed by the CON process. The contention is that a CON program protects inefficient providers and discourages more efficient providers from offering cost-effective services. A certificate of need program can actually inhibit competition and restrict the provision of services at lower costs. By restricting competition, critics argue that certificate of need laws foster inefficient resource allocation to the benefit of regulated entities.

There appears to be little consensus on whether or not CON laws are effective in containing costs. As the health care industry undergoes a shift to a competitive market, the CON regulatory process needs to be modified to reflect the changing system. In Connecticut, as a result of the emergence of integrated health plans, CON laws need to be revised to take into account changes in the health care delivery system.

Table 48. Staffed Beds and Occupancy Rates: FY 1991

HOSPITAL	Staffed Beds	Occupancy Rate
ROCKVILLE	63	100.8 %
MOUNT SINAI	192	91.8 %
ST RAPHAELS	511	89.4 %
VETERANS MEMORIAL	213	87.3 %
DANBURY	424	87.3 %
JOHNSON MEMORIAL	78	86.3 %
NORWALK	346	82.2 %
HARTFORD	916	81.3 %
YALE-NEW HAVEN	832	80.7 %
BRIDGEPORT	515	80.4 %
ST MARY	334	80.1 %
BRISTOL	193	77.8 %
WATERBURY	342	77.7 %
ST FRANCES	580	77.2 %
NEW BRITAIN	362	75.1 %
STAMFORD	299	74.7 %
BACKUS	241	72.7 %
ST VINCENT	423	72.3 %

Table 48. Staffed Beds and Occupancy Rates: FY 1991		
HOSPITAL	Staffed Beds	Occupancy Rate
MIDDLESEX	257	71.6 %
LAWRENCE & MEMORIAL	336	71.6 %
MANCHESTER	251	68.8 %
SHARON	86	68.6 %
CHARLOTTE HUNGERFORD	188	66.3 %
GREENWICH	262	66.3 %
BRADLEY	72	65.4 %
ST JOSEPH	190	65.2 %
PARK CITY	120	64.5 %
WINDHAM	134	59.5 %
DAY KIMBALL	142	59.0 %
GRIFFIN	220	57.7 %
NEW MILFORD	95	57.1 %
MILFORD	161	54.6 %
WINSTED	49	48.9 %
STATE AVERAGE	293	73.3 %

Program review committee staff found the CON laws are ambiguous, particularly in regard to new services or functions. Although a certificate of need is required by statute before facilities may introduce a new service or function, there are no statutory or regulatory rules defining new services. Therefore, a provider must initiate an inquiry to the commission requesting a determination. According to commission staff, requests for expansion of services or functions are reviewed on a case by case basis and then notification is sent to the provider on whether a CON must be filed.

A major goal of the CON program is to limit facility expansion and acquisition of major medical equipment in order to contain costs. Program review committee staff found the vast majority of CONs reviewed were approved by the commission for 1991 and 1992. For example, in 1992 only 2 of the 60 CONs that involved costs were denied by the commission. The total aggregated costs for the 60 CONs was $259,245,236 of which $238,592,346 or 92 percent of the costs were approved. A savings of 8 percent ($20,652,890) does not appear to

be very effective in meeting the goals of the program, and could even have the opposite effect by limiting competition so that those who could provide some services at a lower cost are deterred from entering the market.

Table 49 provides a breakdown of the 60 CONs for 1992 that involved costs, by category. Program review committee staff found that capital expenditures accounted for the largest CONs at over $200,000,000, followed by those involving acquisition of major medical equipment. Most of the CONs decisions involved a new service or function; however this category accounted for the smallest total costs at only $1,725,149.

Table 49. Total Cost and Number of Certificate of Needs by Category for Calendar Year 1992.

CAPITAL EXPENDITURE	MAJOR MEDICAL EQUIPMENT	NEW SERVICE OR FUNCTION	OTHER
$200,035,925 (13)	$23,392,579 (12)	$1,725,149 (31)	$13,438,693 (4)

Source: CHHC Decision Database.

One important feature missing from Connecticut's certificate-of-need program is its connection to state health planning. The purpose of CON is to assure the appropriate allocation of state health care resources. However, there has been no comprehensive health planning in the state since 1985. Thus, for the last several years the decision to allocate resources has been based on scant information with little foresight into future health needs. In the absence of such a plan, it is difficult to understand who determines need and how those needs relate to a submitted CON proposal. This example illustrates one of the major failures of the CON program and questions the efficacy of the program as it is currently operated.

Recommendation

The Legislative Program Review and Investigation Committee recommends that the regulation of hospital budgets and rates be ended. It is further recommended that all payers be allowed to negotiate with hospitals on the delivery of services to their members. It is further recommended that all hospital costs, both inpatient and outpatient services, be monitored with respect to revenues, expenses, and utilization, and the information shall be submitted to the Connecticut Health Care Data Institute. The certificate-of-need program shall be modified based upon recommendations found in the next section of this report.

The cessation of hospital budget and rate regulation will require a transformation of the Commission on Hospitals and Health Care from its current responsibilities to a new agency that will be able to actively and aggressively monitor, assess, and, where necessary, regulate a competitive health care market. Recommendations restructuring the agency and establishing competitive entities are proposed in the next two sections.

CHAPTER VI: FINDINGS AND RECOMMENDATIONS
THE AGENCY FOR HEALTH SYSTEMS

Connecticut's current regulatory structure does not meet the needs of the state's emerging health care market. Efforts at containing costs have been directed at a small segment of health care services, and efforts to provide information on the systems in operation have been minimal. The state lacks comprehensive health planning and has attempted to regulate hospital revenues and expenditures with limited success. The state has not provided incentives for the development of innovative cost-effective delivery systems, and has failed to provide direction towards comprehensive health care cost containment.

The four major pieces of health care management -- financing and developing health plans; cost containment; health systems planning; and access -- are under the jurisdiction of four separate state agencies. The focus of state government is on the regulation of the market for health policies by the Insurance Department, and the regulation of hospital rates and budgets by the Commission on Hospitals and Health Care. The Department of Social Services is responsible for providing access to health care for the poor, but not for the uninsured, and health planning efforts have just begun at the Department of Public Health and Addictive Services. Each agency has specific responsibilities for a portion of health care, but none has purview over the entire system.

This fragmented system of government regulation has not created an environment where providers are rewarded for quality and economy of services delivered. To encourage conditions that allow organizations to continuously strive for better utilization of health care resources, the state must provide guidance and direction for all organizations seeking to improve the health status of Connecticut residents.

Connecticut's health care delivery system would be best served by moving toward a competitive marketplace that is monitored by a centralized state agency. The financing and delivery of health care in Connecticut is undergoing a shift from a fee-for-service solo provider system funded by indemnity insurance to integrated networks of selected providers funded, coordinated, and administered by managed care organizations. The shift will have a significant impact on the direction of cost-containment efforts that are needed to slow the growth of health expenditures. It has been widely recognized that not only is there a need to control the price of health care, but the utilization of health services as well.

If the state is to focus on health care delivery and cost containment, it must do so through a single state agency vested with the authority to structure a marketplace that allows for competition among health care providers, facilities, payers and consumers to yield the best allocation of health care resources. As noted earlier, Connecticut has a large number of buyers and sellers of health care giving the state the unique opportunity to support incentives that make health plans comparable, to establish minimal barriers to entry and exit into the health care

market, and to provide adequate information for buyers and sellers to make purchasing and supply decisions.

It must also be recognized that medical care is a complex product that does not meet the definition of most other consumer goods or services. There is a tendency to consume more health care because of third-party reimbursement (insurance), especially for serious and potentially high cost illnesses. Most consumers delegate the authority for treatment, the basis of health care consumption, to expert providers. As in other markets where insufficient information requires consumers to rely on the advice of producers, the quantity of medical care demanded depends largely on the decisions of suppliers. Because health care providers can influence the volume of services, a reduction in the price per unit of service does not lead to a commensurate reduction in total expenditures.

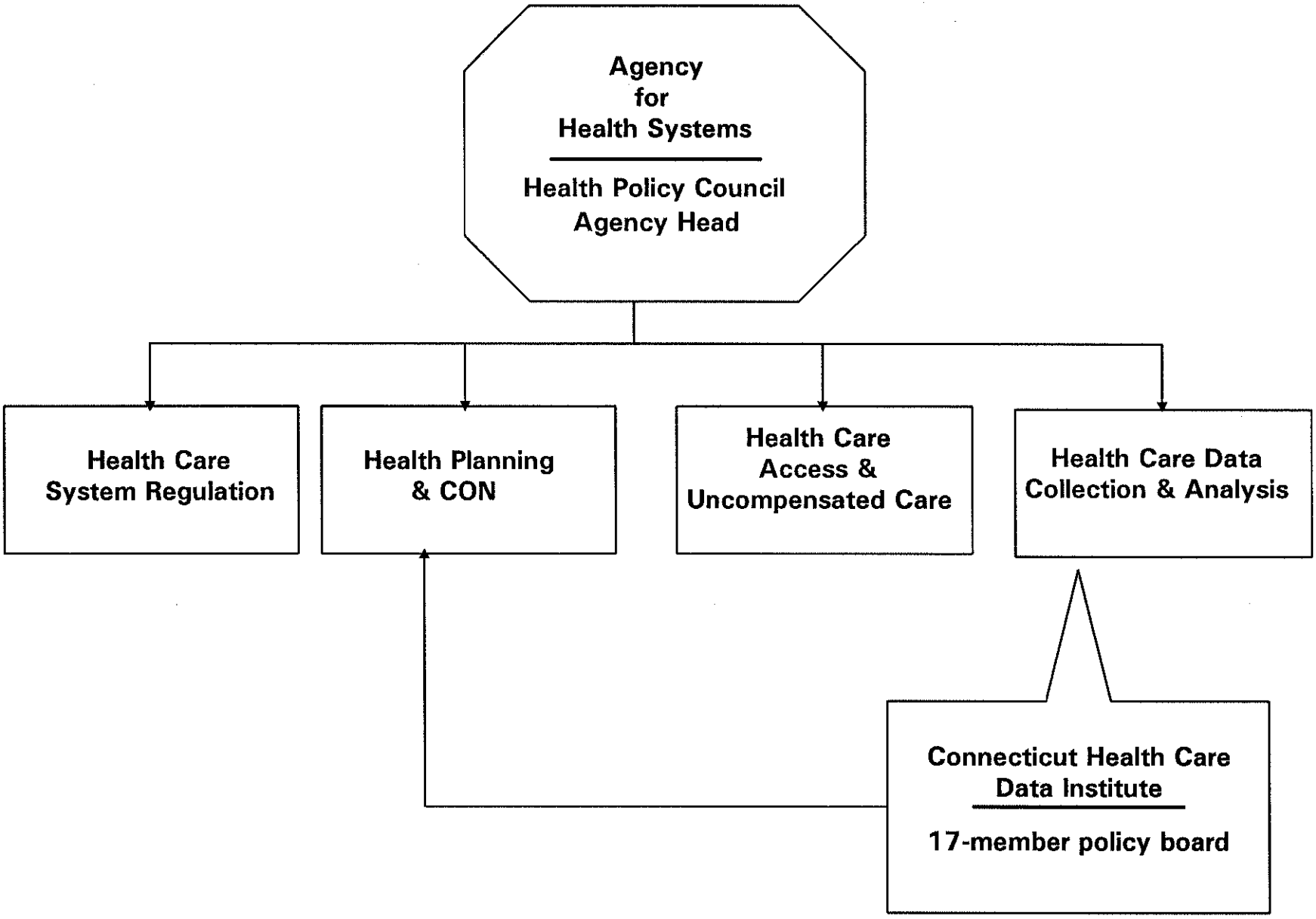
A single state agency will allow Connecticut to establish a regulatory framework for the management of competition in the health care market. The single agency will be responsible for monitoring and assessing health care systems within a competitive environment while maintaining the quality of health care already achieved in Connecticut. The new agency will be required to establish the boundaries for the operation of competitive health systems and strike a balance between private health care and the needs of community health systems. This agency is diagrammed in Figure 6.

The Agency for Health Systems

The Legislative Program Review and Investigation Committee recommends creation of the *Agency for Health Systems*. The agency shall be governed by a health policy council composed of the commissioner of insurance, the commissioner of Public Health and Addictive Services, or their designees, and the commissioner of the Agency for Health Systems. The commissioner of the agency shall be appointed by the governor and is the administrative head. The health policy council shall be responsible for establishing health systems policy, adopting regulations, and certifying and licensing entities under the purview of the agency. The health policy council may designate advisory councils as it deems necessary for the implementation of health policy.

The purpose of the new state entity, the Agency for Health Systems, is to provide oversight in two areas that are currently separate and detached: the regulation of health insurance plans and the provision of health care services. The principal responsibility of this new agency will be to coordinate the interests of insurers, providers, and consumers of health care.

Figure 2: A New Regulatory Structure for Health Care Delivery



Specifically the agency will be responsible for:

- **regulating major capital expenditures and the acquisition of technologically advanced equipment through certificate of need;**
- **certifying all health plans sold in Connecticut;**
- **licensing competitive health plan purchasing cooperatives;**
- **developing a state health plan, in conjunction with the Department of Public Health and Addictive Services;**
- **data collection and information;**
- **establishing incentives for the development of managed care health networks;**
- **obtaining information on contractual arrangements between providers and certified health plans;**
- **tracking health care costs, including hospital revenues and expenditures;**
- **administering the uncompensated care pool;**
- **expanding health care access through insurance for all residents of the state; and**
- **promoting cooperative agreements among hospitals.**

The agency will be composed of four bureaus: Health Planning and Certificate of Need Regulation; Health Care Systems Regulation; Health Care Access and Uncompensated Care; and Health Care Data Collection and Information. These four bureaus shall be responsible for monitoring and regulating a competitive health care market in Connecticut. (This agency would replace the Commission on Hospitals and Health Care, take over the planning functions from the Department of Public Health and Addiction Services, and provide for the regulation of certified health insurance policies.)

Bureau of Health Care Systems Regulation. **This new bureau shall be responsible for regulating all aspects of health care insurance (with the exception of financial solvency) and delivery systems. The agency shall be responsible for carrying out the following statutory provisions:**

- **set standards for and certify health plans to be offered to purchasing cooperatives;**
- **license managed care and utilization review companies and third-party health insurance administrators;**
- **assist in the organization of and license competitive health plan purchasing cooperatives; and**
- **require all contracts between providers, insurers and consumers be filed with the agency.**

Certified health plans. **The agency will be responsible for encouraging the formation of integrated health networks -- systems of health care providers and facilities responsible for managing the care of enrollees -- as certified health plans. The agency shall be responsible for setting standards for certified health plans. Certified health plans shall be**

defined as those plans containing the following basic elements: a contracted network of providers; a managed care and utilization review program; capitated rates to purchasers; a quality assurance program; and the financial and administrative capability to provide reimbursement for services used by enrollees as defined by the plan. Certified health plans shall also conform to the statutory provisions of Part I (Health Care Centers) of Chapter 698a and Part III (Group Health Insurance) and IV (Comprehensive Health Care Plans) of Chapter 700c of the Connecticut General Statutes. In addition to the current statutory provisions, certified health plans shall be standardized to prevent insurers from engaging in risk selection by product differentiation.

Community rating. **Health plans in Connecticut shall be priced based upon the cost of providing health services unrelated to the risk of the insured population, except for two rating factors -- age and geographic area. Geographic area shall be allowable only as it affects the cost differentials related to service provided in different regions of the state. The agency shall establish a risk adjustment methodology for the purpose of insuring that adverse risk selection does not undermine the functioning of purchasing cooperatives and certified health plans.**

Health plans also shall not require an eligible employee or dependent to be subject to medical underwriting, evidence of insurability, or pre-existing condition exclusions as a condition of membership.

Health plans are required to submit data as deemed appropriate for certification by the agency as well as supply data on enrollment and costs as required by the newly created Health Data Institute.

The licensing of insurers and oversight of financial solvency of companies shall continue to be performed by the insurance department.

Dramatic variations in health plans make it difficult for consumers to price compare. Health plans offer a complex set of benefits that can be manipulated to reduce the risk an insurer faces by not covering certain illnesses. The agency should minimize the ability of health plans to reduce costs based upon risk selection rather than reduction in fees and utilization. A key role for the agency is to require the offering of cost-effective plans rather than plans that simply avoid health cost through biased selection. This can best be achieved through the standardization of health plan coverage to allow for comparisons among the plans offered.

Bureau of Health Care Access and Uncompensated Care. **This bureau shall be responsible for determining the current level of access to Connecticut's health care system. The goal shall be to achieve universal access to health care in the most cost-effective manner. In addition, the bureau shall be responsible for administering the state's uncompensated care pool as defined by C. G. S. 19a-168b. The bureau shall also be responsible for insuring that all employers comply with the recommendations regarding competitive health plan purchasing cooperatives. The Agency for Health Systems shall**

study the issue of employer contributions to health plans purchased by cooperatives and report its findings and recommendations to the General Assembly by January 1, 1996.

Access to health care is an important issue that, to date, has not been adequately dealt with on the state level. While much of the uninsured population is covered by charity care, it is not the most efficient way to deliver health services. Uncompensated care has caused an imbalance within our community hospital system by having some institutions, usually urban facilities, bear an inordinate amount of costly charity care. A competitive market system can worsen this condition if efforts are not made to evenly distribute the cost of uncompensated care. This can be achieved by enhancing access to primary care rather than relying on more expensive hospital based services. It should also be achieved by restructuring the uncompensated care pool to insure that it fairly distributes the burden based upon effort and need of hospitals involved in providing care to the uninsured population.

Bureau of Health Planning and Certificate of Need Regulation. **The agency, through this bureau, will have the authority to assess the capacity of Connecticut's health care system to meet the needs of its citizens and regulate large capital expenditures and authorize the purchase of technologically advanced medical equipment for health care. The division would also be responsible for producing a state health plan, in conjunction with the Department of Public Health and Addiction Services.**

A certificate of need shall be required only for significant capital expenditures and acquisition of medical equipment. A significant capital expenditure shall be defined as an expenditure that exceeds $5,000,000. Acquisition of advanced medical equipment shall be defined as medical equipment with costs in excess of $1,000,000. Replacement medical equipment shall be excluded from the certificate of need requirement. Thresholds for capital expenditures and for medical equipment shall be indexed to inflation. The requirement that a certification of need be obtained by a facility or institution to provide a new service or function, terminate a health service, or decrease substantially its total bed capacity shall be repealed.

In addition, the Agency for Health Systems shall adopt guidelines addressing statutory criteria listed in C.G.S. 19a-155 when reviewing certificate of need applications.

The agency shall promote cooperative agreements among hospitals. A cooperative agreement shall be defined as an agreement among two or more hospitals for the sharing, allocation or referral of patients, personnel, instructional programs, support services, and facilities or medical, diagnostic or laboratory facilities or procedures or other services traditionally offered by hospitals. Certificate of need applications that involve cooperative agreements among hospitals shall be given favorable consideration for those hospitals involved in the agreements.

There are several reasons to modify the certificate-of-need program. It is important that there be a independent review process for major capital expenditures and acquisition of major

medical equipment to reduce costly duplication without demonstrated community need. As mentioned previously, a state health plan that assists in identifying the best allocation of resources, in conjunction with integrated health plans that focus on managed care, will be critical in containing costs and maintaining quality. However, a CON process should still be maintained for costly expenditures to allow the state to manage the allocation of resources within the health care system.

Eliminating the review of new services will allow hospitals increased flexibility in a competitive market. They will be able to alter their operations based upon the needs of the community they serve and the health plans they contract with rather than face a lengthy regulatory review process. Hospitals will be required to manage their resources based upon the information they have on demand for services. Most costs associated with a new service are minimal, and the introduction of any major new service would likely have a medical equipment expenditure in excess of the $1,000,000 limit for review. The committee found that in 1992, of the 13 capital expenditure CONs reviewed, 8 of those would still be reviewed under the new $5,000,000 threshold. For medical equipment, 10 of the 12 CONS would require approval under the proposed $1,000,000 threshold. In this way the agency can concentrate its efforts on high cost health care expenditures.

Health care is an important public good and access to services is necessary; thus it is crucial that decisions be made on the basis of a comprehensive state health plan that will guide the allocation of resources. However, the plan must be enforceable if the desired result is equitable distribution and cost containment. In the absence of health planning, the CON program is simply a mechanism to restrict competition and maintain the status quo.

With the growth of competing certified health plans seeking out cost-effective services, there are clear financial incentives for hospitals not to overinvest in beds or medical equipment, particularly if they will be underutilized. Certified health plans, because of their strong managed care component, will control utilization and thus contain unnecessary hospital growth. Under a managed care environment where providers are selected and fees negotiated, the risk of excess expenditures and underutilization will be borne by the facility.

Conversely, one of the main purposes for preserving the CON program is to ensure poor persons access to services in urban settings. Since hospitals are required to serve a large proportion of the under- and uninsured populations, charges for services are usually more expensive in a hospital setting than in a private office. In order to assure that adequate resources are available, as well as access to services in an urban setting, the certificate of need program should be maintained.

Federal and state regulations governing hospital operations and reimbursement have constrained hospitals in developing new cost-effective methods for the provision of hospital services. Cooperative agreements among hospitals, promoted by certified health plans and the agency, will foster further improvements in the quality of care, moderate increases in costs,

improve access to needed services, and enhance the likelihood of smaller hospitals surviving in a competitive market.

Bureau of Health Care Data Collection and Analysis. **The bureau shall be responsible for staffing the Health Care Data Institute. The bureau would also continue to monitor health care costs and supply the necessary data and information needed for the state health plan.**

Connecticut Health Data Institute

In Connecticut, information on both the financing and delivery of health care is severely lacking. For a competitive health care market to operate properly, the state needs both comprehensive information and authority to establish regulatory boundaries. Without thorough information, it is impossible to assess and monitor the health care delivery system. Information is the core of any regulatory process and is crucial to ensure marketplace equilibrium.

Private initiatives. Several organizations in private industry have recognized the lack of uniformity and availability of health care data. Two separate groups have formed: one to create administrative efficiencies in the health care market by developing electronic data interchange capabilities; and the other to develop performance measures for health plans so comparisons can be drawn. In addition to these efforts, individual health plans have begun to develop their own accountability measures in order to distinguish themselves from competitors' health plans and gain an advantage in the marketplace.

Insurers and providers in the health care industry established the Workgroup for Electronic Data Interchange (WEDI) in which Connecticut is a leader and a national model. Using the existing technological capability of all participants, the Connecticut Electronic Data Interchange Project plans to develop an integrated and interactive network in Connecticut to electronically transmit membership eligibility, coverage determination, claims processing, and payments. Its goal is to achieve an entirely electronic-based health insurance system in Connecticut thus reducing paperwork and confusion for patients, providers, employers, and payers.

Another major national undertaking on data collection is the Health Plan Employer Data and Information Set (HEDIS) 2.0[23] developed by a group of employers and health plan administrators. HEDIS defines a core set of performance measures to be used in assessing health plans. As the number and types of health plans increase, employers want to know if the costs and quality of the services provided by each health plan represent true "value" for their health care dollar. HEDIS uses a common set of reporting standards so that each health plan can be systematically evaluated and held accountable for its performance. There is a recognition

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[23] *Health Employer Data and Information Set,* National Committee for Quality Assurance, Washington, D.C., 1993.

that HEDIS 2.0 is not static and will be constantly evolving as the measurement system is refined.

In addition to efforts by private industry, several states that have undergone health care reform identified the need for more comprehensive health care delivery and financing information. The response of the states has been to create repositories for collection and dissemination of information. These states include Minnesota, Washington, and Florida.

State initiatives. As previously noted, the regulatory structure in Connecticut splits oversight of the health care industry across several departments and is not designed to provide a thorough overview of how health care services are provided and financed. Other components of the system are autonomous and free of state regulatory requirements, so that a global picture of the health care market in Connecticut cannot be constructed.

The four state agencies involved in regulating health care all require certain data to be filed by the regulated entity. However, since responsibility is not consolidated, several data problems exist. First, data are not available from a single source, but scattered across the various agencies. Often data are stored in different formats so that they cannot always be interfaced and aggregated. Furthermore, confidentiality issues about sharing data arise, even between state agencies. Finally, since no agency is concerned with the entire health care market, no efforts are made to comprehensively examine the system.

The primary focus of CHHC is on hospital budget and rate review. Although extensive information is collected for each hospital on inpatient operations, and general outpatient operations, information on non-hospital services or services provided outside the hospital environment (e.g. physician, pharmaceutical, laboratory, or surgi-centers) is not available.

Although the Department of Insurance is responsible for regulating insurance companies offering health products, the department is primarily concerned with regulating the financial solvency of insurance companies and protecting health insurance policyholders from unfair and deceptive policies and practices. Department efforts center on policy substance and compliance with statutory requirements, rather than analyses of health plan enrollment, premium information, cost containment efforts, and changes in the marketplace. Currently, the department reviews all health forms related to individual and group health policies to ensure they meet all department regulatory standards. In addition the department approves premium rates for individual health plans, but not for group policies.

Complete information on health care enrollment and financing for Medicaid is available through the Department of Social Services and for Medicare from the federal Department of Health and Human Services. In addition, the Department of Insurance gathers this information from HMOs, but for commercial insurers only financial data are collected. However, neither enrollment nor financing data are collected on individuals insured by employers who self-insure under the Employment Retirement and Income Security Act (ERISA) preemptions, and for union employees who are insured through Taft-Hartley Health Funds.

Inadequate data have perpetuated a system in which health care choices are not made on the basis of quality or cost. As the number of health plans offered by insurers and HMOs have increased, it is even more imperative that consumers have quantifiable information which gives them the ability to knowledgeably select a plan that provides value and meets their needs. Data that integrates information on delivery and financing of health care would allow consumers to compare health plans and choose between them. Furthermore, analyses that provide comparisons between the many health plans offered to consumers will facilitate competition in the health care marketplace.

Given that information needed to monitor and support a competitive health care delivery system in the state is totally inadequate, Connecticut must support serious efforts to establish a state-wide data repository.

The Legislative Program Review and Investigations Committee recommends the creation of the Connecticut Health Data Institute which shall be responsible for the collection of information on the financing and provision of health care. The institute's mission is to create a state-wide data repository for a centralized cost and quality data system which can be used by both the public and private sectors. The data shall include information from health care providers, health care facilities, integrated health plans, and competitive health plan purchasing cooperatives, premiums, claims, enrollment and outcomes. Certified health plans are required to report data deemed necessary by the institute.

The institute shall be governed by a 17-member board that is representative of the provider community, academic institutions involved in medical research, employers, consumers, and insurers. Eight members of the board shall be appointed by the General Assembly as follows: The president pro tempore of the senate, minority leader of the senate, speaker of the house of representatives and minority leader of the house of representatives shall each appoint two members. The other six members shall be appointed by the governor. Members of the board shall be comprised of:

- **2 representatives from hospitals;**
- **3 health plan carrier representatives;**
- **2 consumers;**
- **3 members from a Competitive Health Plan Purchasing Cooperative;**
- **2 physicians;**
- **2 members from an academic research institution; and**
- **3 representatives of state government as follows: the commissioner of the Agency for Health Systems; the commissioner of the Department of Public Health and Addiction Services; and the**

commissioner of the Department of Insurance, or their designees.

The Agency for Health Systems shall provide staff for the Health Data Institute, except for the executive director who will be appointed by a majority vote of the Board.

The board is required to establish the methodology for data collection and for providing direction on what data would be useful to the plans, providers, consumers, purchasers, and researchers. The data institute is required to adopt standards for collection of cost, spending, quality, outcome, and utilization data; and for the analysis and dissemination by private sector entities of information on costs, spending, quality, outcomes, and utilization provided to the private sector entities by the data institute. The board is also required to establish a policy on the confidentiality of data. The board is granted the authority to contract with private organizations to carry out the data collection initiatives.

The health policy council, in consultation with the board of the Connecticut Health Data Institute, is required to develop a Data Collection Plan. The plan must identify:

- **data collection objectives, strategies, priorities, cost estimates, administrative and operational guidelines, and timelines;**

- **encounter level data (data related to the utilization of health care services by and the provision of health care services to individual patients, enrollees, or insureds, including claims data, abstracts of medical records, and data from patient interviews and patient surveys).**

The data institute shall have the authority to levy a charge for data provided.

The program review committee believes that creating a Health Data Institute will serve a multitude of purposes. First, it will aid consumers in selecting the most appropriate health plan for themselves and their families by providing them with the capacity to analyze benefit plans. Access and availability of information will also give researchers and providers the capability to evaluate clinical effectiveness. The institute will also fulfill another critical function -- providing timely and relevant information to state health regulators and health planners on all facets of the health system. Finally, the comprehensiveness of the data collected by the institute, coupled with the comparability of health plan benefits, will foster competitiveness among health plans and providers, and encourage a more cost effective and quality-driven system.

The Agency for Health Systems, responsible for comprehensive health planning and regulation for the state, will be better served if given access to a extensive body of health care

delivery information. Furthermore, a linkage between the state health plan and the certificate of need (CON) program can be established, identifying existing resources and forecasting future needs, which is essential for resource allocation.

The Health Data Institute will be governed by a board of directors, representative of the provider community, academic institutions involved in medical research, employers, consumers, and insurers. The composition of the board will help promote a spirit of cooperation and consensus where information would be viewed as a community resource, not for its competitive advantage or regulatory peril. The institute's primary function would be as a repository for and disseminator of health care data.

The data institute's staff will be provided by the Agency for Health Systems, except for the executive director, who will serve at the pleasure of the board. The institute will serve the new agency well by freeing that agency from its data collection role, and instead allowing it to concentrate on health planning including the newly configured certificate of need process, analyzing market place information such as insurance premiums, enrollment, managed care contracts, purchasing cooperatives, uncompensated care pool and quality assurance.

Health care data should include both patient specific information and descriptive and financial aggregate data. Some of the measures that could be included are:

- premium/enrollment information;
- diagnoses/claims information;
- quality information;
- outcome information;
- actual revenue information;
- consumer information (patient or enrollee satisfaction); and
- market information (number of certified health plans, managed care procedures, and utilization review agencies, third-party administrators, and health insurance purchasing cooperatives).

Several types of analyses could be expected from this. Participants could use the information to improve practice patterns, as well as track cost and quality of care, utilization review, total health care expenditures and other measurements. The data institute and data repository will provide Connecticut with the necessary tools to reform the health care system in an informed and knowledgeable fashion.

CHAPTER VII: FINDINGS AND RECOMMENDATIONS
COMPETITIVE HEALTH PLAN PURCHASING COOPERATIVES

The focus of competition must shift from health insurers, so prevalent in Connecticut, to competition among health plans. An environment of competing health plans will create incentives for groups of providers, physicians, hospitals, health professionals, and insurers to provide higher value, lower cost health care than is offered under Connecticut's current fee-for-service and hospital regulation payment system. The previous recommendations on certified health plans will require providers and insurers to organize into integrated networks linked by administrative and management structures having the financial and medical capability to serve patients. The following recommendation will require the same organization of the purchasers of health care so they too can achieve savings through size, negotiation, and information.

While choice of certified health plans is one key to a competitively functioning marketplace, organizing large groups of consumers to purchase health insurance is the other. As noted earlier, small employers lack the size and resources to offer multiple health plans to their employees. Individual employers must accept prices and are at a distinct disadvantage because the volume of business, and the risk associated with it, that individual employers bring to plans is not large enough to allow for negotiation of cost. Organizing consumers into large groups of purchasers will permit a dynamic market to develop. Figure 7 diagrams this market structure that aims to foster a competitive environment regulated by state government. Organized groups of consumers, through employers, will enhance choice and force price negotiation among health plans seeking customers.

To create an environment where providers can be rewarded based upon quality and cost of the care, three conditions must be met.

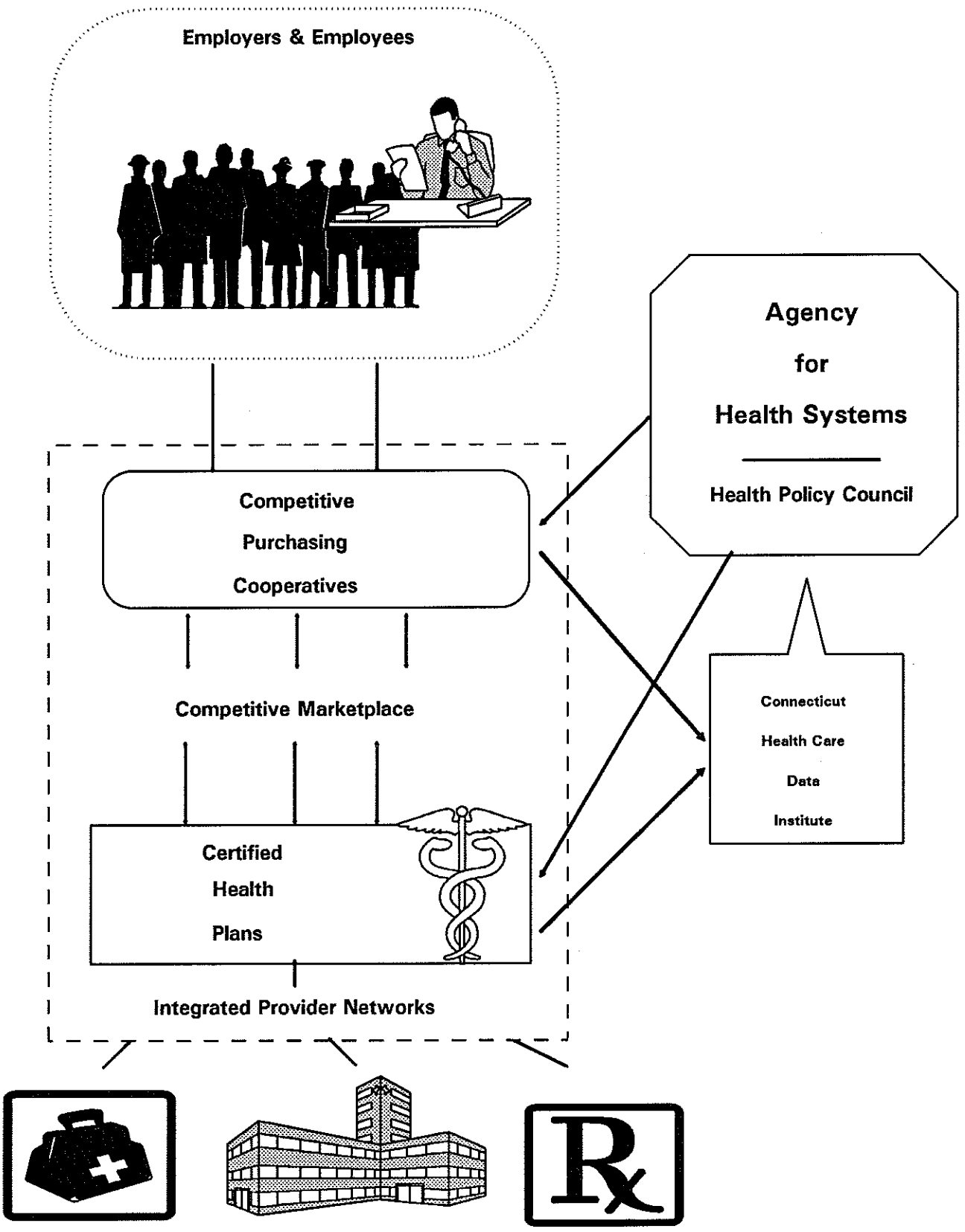
- First, integrated health plans, rather than fee-for-service indemnity insurance, must be marketed to consumers.

- Second, informed employers through purchasing cooperatives, must initially select cost-effective health plans that have arranged the provider community into integrated service networks (health plans).

- Finally, consumers must choose among competing plans selected by their employers based upon their preference for quality and service.

The first condition can be met through certification of health plans by the new Agency for Health Systems. Only health plans meeting the requirements set forth by law and agency regulation would be allowed into the marketplace. The last two conditions can be met through large, highly organized, health purchasing organizations that work to the benefit of employers and employees.

Figure 7: Dynamic Market & Regulatory Structure



Purchasing cooperatives would establish two levels of choice. First the cooperative would evaluate certified health plans interested in offering services to members and contract with some, but not all, plans based upon a competitive bidding process. Purchasing cooperatives would be responsible for negotiating with certified health plans on details of price and service for members. Once the purchasing cooperative selected several cost-effective plans, employees would become involved in the second level of choice. In this second step, consumers would exercise their preference for plans that provided the greatest value for services offered. Purchasing cooperatives would be responsible for obtaining information on plans so consumers could make an informed decision.

Competitive Health Plan Purchasing Cooperatives. **The Legislative Program Review and Investigations Committee recommends the establishment of a corporate entity entitled "competitive health plan purchasing cooperative" which is allowed to organize as a non-stock, not-for-profit corporation or as a for profit corporation and whose primary function would be to offer multiple certified health plans to members. The Agency for Health Systems shall set standards for the licensure of competitive health plan purchasing cooperatives (CHPPCs). Competitive health plan purchasing cooperatives shall not be allowed to take insurance risk. If a non-stock, not-for-profit entity is created, the corporation's board of directors shall have employer and employee representation. For profit corporations must form an advisory board composed of employers and employees for purposes of advising the corporation's management.**

It is further recommended that only certified health plans be offered exclusively to competitive health plan purchasing cooperatives.

Cooperatives shall be required to reach a minimum size of 20,000 insured lives within three years of their initial license application to the agency. The cooperatives shall offer at least three certified plans to their members. Cooperatives shall perform, at a minimum, the following functions: 1) enrolling members; 2) collecting and distributing premiums; 3) establishing specifications for contracting of health plans competitively; and 4) providing consumer information on cost and quality of competing plans.

The Agency for Health Systems shall, by regulation, establish appropriate business practices for CHPPCs. The agency shall have the authority to transfer business from a non-functioning entity, as determined by the agency, to a functioning one. The agency shall also insure that requirements established for joining a purchasing cooperative not result in the selection of members or employers by health risk.

Employers. **All Connecticut employers are required to participate in a competitive health plan purchasing cooperative. Employers are free to choose, to join, or to form cooperatives as they deem appropriate and are guaranteed acceptance into any cooperative if they meet the requirements established by the cooperative.**

Access to health care. **The Agency for Health Systems shall study the issue of employer contributions to health plans purchased by cooperatives and report its findings and recommendations to the General Assembly on January 1, 1996. Any employer not joining or forming a cooperative shall be assigned to one by the Agency for Health Systems.**

The purchasing cooperative proposed by these recommendations will require the consumer side of the market to be organized to purchase of health insurance. The recommendations will require all employers to participate in groups with a minimum membership of 20,000 lives. It is expected that most purchasing cooperatives will in fact be much larger and offer health plans with significant patient volume in exchange for quality health care at an affordable price. Adverse selection of health risk diminishes significantly as the size of the group increases which will allow for the price of plans to be based upon cost-containment efforts rather than limit benefits.

It has been estimated that 75 percent of the uninsured in Connecticut have incomes over twice the poverty level, the highest percentage in the nation[24]. Given the fact that small employers account for the largest proportion of the uninsured population, creating purchasing cooperatives will offer greater choice at less cost to both employees and employers. While this recommendation will not guarantee universal coverage, it will, if implemented, reduce the uninsured population and expand access to health care significantly.

Purchasing Cooperatives in Practice

The California Public Employees Retirement System (CalPERS). One of the most successful and largest organizations purchasing health plans is run in the state of California. CalPERS is a working model of a health insurance purchasing cooperative. It purchases health plans from 18 health maintenance organizations and a number of preferred provider organizations for over 920,000 individuals. The program is open to any public employer, state municipal, county, quasi-public, or special district. CalPERS has 754 employers participating in the program that range in size from a 2 person special service district to 626,000 state employees. The agency spends $1.3 billion in premiums on behalf of its members and has an administrative cost of only ***one-half of one percent*** of premiums.

The agency, which provide pension and portfolio management as well as the health benefits program, is governed by a 13-member board composed of elected individuals and legislative and gubernatorial appointments. The board has exclusive authority and independence in the operation and administration of programs.

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[24] U.S. Census Population Survey, Three-year merged average: 1989, 1992, and 1992, *State-Level Data Book on Health Care Access and Financing*, The Urban Institute, Washington, D.C, 1993.

The agency has met with great success having added over 174 employers in the last two years. It has also succeeded in controlling costs, having kept the premium increase to 6.2 percent in 1992 when health care inflation was running at 12 to 13 percent in California for an estimated savings of $90 million.

In testimony before Congress, Tom Elkin, the CalPERS executive in charge of operations, cited four key features to a successful health benefits purchasing program. The elements of the model are: 1) aggressive premium negotiation for multiple employers; 2) a standard benefit design for all members; 3) cost and performance data collection on plan operations; and 4) strong consumer and employer commitment to the program's operation. He indicated CalPERS has been improving on each one of these and its success can best be measured by the number of new employers joining CalPERS. He further believes that many of the systems and techniques used by the agency can be transferred to the private sector.[25]

One of the strengths of CalPERS is its ability to provide affordable insurance without regard to sex, age, pre-existing condition, or geographic location. All employers participate in single state-wide premium for each plan regardless of their size, location, or age of their members. Because the administrative costs and risks are spread over a large pool, the agency is able to provide comprehensive services at low rates.

However, operating a purchasing cooperative is more than just getting the lowest price for health insurance. According to Elkin, the agency must provide a full range of services to its employers and their employees. Those services include the following:

- enrollment processing;
- premium collection, distribution and adjustments;
- audits to prevent double coverage and ineligibility;
- annual open period for plan selection;
- production and distribution of health plan benefit information;
- member complaint resolution and appeal processing;
- premium negotiations;
- consumer surveys and quality assurance monitoring;
- contract compliance and monitoring;
- provider access review;
- employer assistance and training; and
- cost and quality outcome data collection.

To function properly, a purchasing cooperative must be able to serve the needs of its members. In the case of CalPERS, joining the cooperative is purely voluntary and any employer not satisfied may withdraw from participation in the program.

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[25] Tom Elkin, testimony before the Committee on Labor and Human Resources, United States Senate, 102nd Congress, 2nd Session, December 16 and 17, 1992, pp. 115-127.

CalPERS was very successful in 1994 negotiating with its 18 health plan providers. It has kept its premium increases over the past three years to 6.4 percent compared to the national average of 30.1 percent. For its 1994-95 contracts, they were able to negotiate a 1.1 percent decrease in the average premium charged, thus forcing the health plans to become even more aggressive with cutting costs and managing care[26].

Connecticut's Experience with Health Insurance Purchasing Cooperatives

Connecticut's experience with health insurance purchasing cooperatives is limited, though group purchasing arrangements have begun to increase over the last several years. Most health insurance is purchased by employers either directly from an insurance carrier, from health maintenance organizations, or from insurance brokers and agents.

A group purchasing organization that most closely resembles the one proposed in this study is the state of Connecticut's health benefits program. While still in the early stages of development and not nearly as experienced as the California program, the state has been successful in purchasing multiple managed health plans on a competitive basis as well as offering choice to employees.

The state of Connecticut insures over 130,000 lives of current and retired employees and their families. Given its size, the state represents a significant purchaser of health care. The state created the Health Care Cost Containment Committee to examine issues related to benefit plans and the cost of providing care. The committee, composed of labor and management personnel, was responsible for shifting all employees to managed health care. The committee established criteria for health insurance plans and received bids. Selections of competing plans were made and became available to employees who then chose the plans they preferred.

Several private organizations have also been operating group purchasing arrangements. One, which has operated for a number of years, is the Connecticut Business and Industry Association Service Corporation. CBIA Service Corporation provides group health insurance to member companies with 200 or fewer employees. Currently, the corporation is supplying 5,000 small employers with insurance plans that cover 100,000 employees and their families. Approximately $175 million in insurance premiums is collected.

The CBIA Service Corporation acts as an intermediary between insurers and small employers. The corporation administrates and manages the plans it offers, through its underwriter - the Aetna -- to their industry members. The corporation negotiates rates with a single insurer, product development, and establishes claim processing performance standards. In addition, the corporation performs key administrative functions such as enrolling members,

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[26] Marilyn Chase and Carrie Dolan, *CalPERS Proves Insurance Costs Can Be Reduced*, Wall Street Journal, February, 10, 1994.

maintaining historical claims data, and billing and forwarding premiums. It also assists in underwriting new members and health plan development.

Another example of group purchasing is the Connecticut Coalition of the Taft-Hartley Health Funds, Inc. representing approximately 132,000 enrollees. The coalition is a state-wide organization representing labor-management negotiated health plan funds authorized by the federal "National Labor Relations Act". Each member operates its own fund controlled by representatives (trustees) of employers and unions. The trustees determine the benefits to be included within each fund's health plan. The benefits and costs are based on each union's negotiated hourly contribution made on behalf each employee by their employer. By offering multiple health plans, the coalition is attempting to consolidate its buying power in order to negotiate more favorable rates with health care providers.

A third association attempting to organize as a health insurance purchasing cooperative is the Employer Health Care Coalition of Connecticut. This coalition has strived "to give small and mid-sized companies who band together the same marketing clout ... and buying power...." as large corporations.[27] According to testimony received by the program review committee, the coalition plan is to purchase health coverage for 150,000 members.

An Alternative to Competitive Purchasing Cooperatives

As an alternative to what is currently taking place in many states, proposals have been made to create a single purchasing authority for a given geographic region. This authority would be responsible for selecting health plans for employers who would in turn offer those plans to their employees. This single authority would be responsible for providing all the services of purchasing cooperatives.

In a recent article by Paul Starr on the design of health insurance purchasing cooperatives (HIPCs), he notes that

> One reason to resist generally transforming the HIPCs from the role of purchasing to planning organizations is that it will jeopardize their special role as the agents of purchasers. A purchasing cooperative ought to be recognized, first and foremost, as the arm of the purchasers -- that is, consumers and employers. Control of the purchasing cooperative should rest with them. If, by contrast, the HIPC is turned into a comprehensive financing and planning organization,

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[27] Testimony of Bernard Forand, President, Employer Health Care Coalition of Connecticut, Testimony before the joint committee meeting of public health and program review and investigations, Health Care Cost Containment Forum, October 26, 1993, p.78.

demands for provider representation will be difficult to deny, and, if the past is any guide, capture by provider interests will be hard to avoid.[28]

In addition to Starr's reservations concerning the role of cooperatives, other key questions have been raised about problems of geographic monopoly insurance purchasing cooperatives. First, if the cooperative is given a monopoly over services how will consumers be assured that it is acting in the public interest? This would require the creation of an elaborate governing mechanism to insure that such a large organization, likely to have at least 1 million members and responsibility for one-third of the health care premiums (estimated to be over $3 billion) in Connecticut, would be responsive to all the consumers. Given its immense influence in the marketplace, providers would certainly want to have a say in its operations.

If a monopoly cooperative selects only a few plans, would this create barriers to market entry for innovative and cost-efficient providers? Plans which were not selected would likely not continue to operate within a given geographic area as they would lose their network of providers and other cost containment mechanisms. This would ultimately lead to fewer plans being offered and the curtailment rather than enhancement of competition. According to economic theory, most competition is likely to come from new products or ideas rather than from producing old products at a slightly lower cost. Under a system where a single authority would control market entry, barriers to the market would be formidable.

Holding large purchasing cooperatives with monopoly power accountable for the work will require a regulatory system to be in place to oversee its operation. Given the size, it will have enormous administrative responsibilities for premium collection and health plan selection for all its members.

It would be extremely difficult to reject a plan that had achieved significant market share. In the event that only a few firms are left to offer health plans, the purchasing authority would become a price regulator rather than a price negotiator, which would subject the cooperative to "regulatory capture". A choice must be made as to whether the purchasing cooperative is in fact to be a regulatory entity or whether its sole function is to provide for the organization of the demand side of health care.

Finally, for purchasing alliances or cooperatives to significantly contain health care costs, individual consumers would have to make choices that favored the lowest cost plans offered by the alliances. Given the fact that most consumers of health insurance pay less than 20 percent of the actual cost, there is little incentive for consumers to make choices based upon price. The actual cost impact is further eroded by the tax-deductibility of health insurance premiums faced by individuals. If consumers faced the true cost of insurance, they would be more sensitive to

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[28] Paul Starr, *Design of Health Insurance Purchasing Cooperatives*, Health Affairs, Supplement 1993.

the price differences. However, because they only incur a small margin of the total cost, consumer decisions are based upon the quality and access of health services rather than cost. Competing health plan purchasing cooperatives, working on behalf of their members, are in a much better position to negotiate the premiums charged by health plans than individuals making choices through a large alliance.

Appendix A

History of Cost Containment in Connecticut

Connecticut has a long history of monitoring and seeking to contain health care costs. Beginning in 1949, the Connecticut General Assembly created a hospital cost commission responsible for collecting annual data on medical costs and establishing reimbursable costs for services delivered to public program recipients. As public assistance programs grew, the commission's authority was expanded to include setting rates for government paid patients. This function was transferred to the Department of Income Maintenance in 1977, who continues to be responsible for determining Medicaid and state-funded medical assistance rates.

A private cost containment project was initiated in 1969 when the Connecticut Hospital Association and Blue Cross jointly formed the Connecticut Hospital Planning Commission, Inc. This commission's major focus was to review capital expenditures in excess of $150,000 to determine if the project was necessary. The hospitals and Blue Cross agreed not to reimburse any hospital for a project that was not approved by the planning commission.

In 1969, the legislature (Public Act 693) established the Council on Hospitals, a joint public/private body which included members from the Departments of Health Services, and Mental Health, the Connecticut Hospital Association, and the nursing home industry. The council was given specific functions, but no authority to enforce any decisions. This body was mandated to review capital expenditures in excess of $250,000, study health facility rates, provide cost data to the insurance commissioner, and evaluate charges, reimbursement arrangements and the quality of health care.

Public Act 73-117 created the Commission on Hospitals and Health Care with responsibility to control health care costs, improve delivery of health care services, and conduct a continuing state-wide review of health care facility utilization. Its membership included the commissioners of health, mental health, and insurance; eight public members; one hospital administrator; one nursing home administrator; and one physician. The commission was originally mandated to approve:

- rates for nonstate-owned hospitals and nursing homes if rates exceeded statutorily fixed annual percentages;
- operating and capital expenditure budgets for nonstate-owned hospital;
- capital expenditures in excess of $25,000 for all health care facilities; and
- new services or functions proposed by any health care facility.

The powers given to the commission were unique in that it permitted the commission to not only approve rates, but also prospectively review and approve the entire operating and capital budgets of the state's 35 short-term acute care hospitals. To control the growth of hospital costs, the legislature cited the need to control not only the rates charged for hospital services but the volume of services as well. The legislature recognized that the regulation solely of rates might simply result in an increase in service intensity and volume, having little impact on the bottom line of hospital expenditures.

Since 1973, the commission has undergone several changes to its statutory mandates. The changes have focused on the size of the commission, criteria used during its deliberations, and the scope of regulatory authority.

In addition to the commission's responsibilities, there has been legislation, especially in recent years to assign greater responsibilities to the Departments of Insurance, Social Services, and Public Health and Addiction Services. Since 1985 legislative initiatives impacting the health care field can be categorized into six broad categories:

- access to health care;
- hospital discounts - affecting percent allowed and eligibility;
- budget/rate review - affecting review formulas;
- certificate of need - affecting thresholds for review and type of proposals requiring review;
- uncompensated care pool; and
- commission composition.

A list of major public acts that impacted the health care delivery system in the state since the commissions inception is provided below.

Appendix A. Major Legislation Affecting Commission on Hospitals and Health Care (CHHC).	
Public Act No.	**Purpose**
P.A. 73-117	Created Commission on Hospitals and Health Care composed of 15 part-time commissioners, vested with budget and rate review authority for hospitals and nursing homes, and Certificate of Need (CON) approval.
P.A. 75-562	Established Statewide Health Coordinating Council (SHCC) as required by federal law to advise the Health Department in the preparation and revision of the state health plan.
P.A. 76-256	Required commission to consider a variety of criteria (based on quality, need, and cost) for CON, rate and budget approval.
P.A. 77-192	Increased number of commissioners from 15 to 17 members. Brought state-operated facilities under CHHC jurisdiction for approval of new services and functions, and major capital expenditures. Raised CON threshold for capital expenditures from over $25,000 to over $50,000.
P.A. 78-264	Required CHHC to determine annually all rates to be charged by licensed home health care agencies and homemaker-home health aide agencies including rates for services to state-assisted patients.
P.A. 79-182	Transferred CHHC authority to establish private nursing home rates to Department of Income Maintenance.
P.A. 80-7	Required CHHC approval of rates to be charged by home-health agencies.
P.A. 80-19	Created expedited hearing process for certain CONs (i.e. compliance with state/local health, fire, safety codes).
P.A. 80-72	Changed CON monetary thresholds: • increased capital expenditures from $50,001 to $100,000; • decreased land acquisition from $100,000 to $50,000; • increased replacement equipment from $100,000 to $150,000.
P.A. 80-73	Authorized CHHC to modify, as well as approve or deny, applications involving the transfer of nursing homes.
P.A. 80-74	Eliminated CHHC authority to extend CON review period by 30 days.
P.A. 81-159	Allowed for waiver of public hearing for certain CONs.
P.A. 81-211	Expanded CHHC authority to review nursing home facilities proposal to decrease its services to Medicaid.
P.A. 81-441	Amended CON review process: • exempting HMOs from review providing outpatient services; • extending review to a facility planning to terminate a health service or substantially decrease its bed capacity.

Appendix A. Major Legislation Affecting Commission on Hospitals and Health Care (CHHC).	
Public Act No.	**Purpose**
P.A. 81-465	Restructured CHHC: • Reduced number of commissioners from 17 to 3 members who would be appointed by the governor; • Established a superscreen process for budget review and exemptions; • Modified certain capital expenditure thresholds and procedures.
P.A. 83-215	Amended CON process by: • changed allowable review time-frame; • required CON for any person proposing to acquire or lease imaging equipment costing in excess of $400,000 which will not be owned by a health care facility; • exempted programs of ambulatory services conducted by HMOs from the CON process; • changed capital threshold to $600,000 for capital expenditures and $400,000 for major medical equipment.
P.A. 84-57	Modified formula for hospital to be exempt from budget review.
P.A. 84-315	Created task force to develop and implement a prospective payment system (PPS).
P.a. 84-323	Allowed HMOs to directly negotiate discounts with hospitals and phased out and eliminate BC/BS ability to negotiate additional discount by 1989. Set thresholds for discounts for prompt payment and administrative services for other payors.
P.A. 85-89	Raised CON capital expenditure threshold from $600,000 to $71400.
P.A. 87-192	Raised CON capital expenditure threshold from $714,000 to $1,000,000. Allows CHHC to extend CON review period by a maximum of 30 days if the applicant cannot provide necessary information on time. Allows applicant to extend review period by 15 days.
P.A. 87-420	Designated Department of Health Services as lead agency for public health planning in the state. Repealed the Statewide Health Coordinating Council and all statutory references to the federally created health systems agencies (HSAs).
P.A. 87-443	Changed how CHHC established rates charged by hospitals under the Prospective Payment System. Allowed rate increases based on inflation and other factors.
P.A. 88-110	Required group accident and health insurance policies to provide coverage for eight benefits: mental illness, injury or sickness to newborn infants, accidental ingestion or consumption of a controlled drug, home health care, emergency ambulance services, nurse practitioners, alcoholism treatment, and right to continue coverage after ineligibility to convert group coverage to individual coverage.
P.A. 88-357	Amended hospital PPS by clarifying that workers' compensation payers must pay fixed charges based on DRGs. Amended appeal procedures under PPS.
P.A. 89-72	Eliminated requirement that CHHC hold hearings on CON applications of a similar nature at the same time.

Appendix A. Major Legislation Affecting Commission on Hospitals and Health Care (CHHC).	
Public Act No.	**Purpose**
P.A. 89-325	Act allowed: • nursing homes participating in both Medicare and Medicaid to expand once without obtaining CHHC approval. Limits expansion to 10 addition bed with total capital costs not to exceed $30,000 per bed (annually adjusted for inflation); • facilities to drop out of the Medicaid program or decrease their Medicaid services without prior CHHC approval.
P.A. 89-371	Eliminated hospital PPS and its related Diagnosis Related Group (DRG) method of regulating hospital billing. Instead established a system to prospectively set gross and net revenue caps for each hospital. Staring on October 1, 1990 net revenue cap was equal to inflation plus two percent. Provided criteria for budget review and exemption, but required detailed budget review at least once every three years. Increased the number of CHHC commissioners from three to five members. Required commission review of each hospitals uncompensated care. Added new criteria that must be considered by the commission for deliberation on proposals concerning rates, services, CONs and budgets: • effect of proposal on health care consumers and on payers for health services; • whether there is a clear public need for the proposal; • whether the facility can competently provide efficient and adequate service and is technically, managerially, and financially able to do so; and • whether rates are sufficient to allow the facility to cover its reasonable capital and operating costs.
P.A. 90-134	The Act: • expanded access to and increased availability of health care services and insurance coverage to people without health insurance or with inadequate coverage; • established Small Employers Health Reinsurance Pool which required creation of "special health care plans" offered by health insurers and HMOS for a limited time to small employers who are not offering their employees any coverage (also available to certain low-income individuals through the existing Health Reinsurance Association (HRA)); • allowed CHHC to develop a plan to lower the Medicare cost shift to other payers and a method to improve its hospital charge data; • created the Health Care Access Commission.
P.A. 91-48	Eliminated requirement that long-term care facilities file comprehensive information concerning their business interests annually to CHHC (retained filing with DOHS); Gave CHHC 10 business instead of calendar days to review emergency CONs.

Appendix A. Major Legislation Affecting Commission on Hospitals and Health Care (CHHC).	
Public Act No.	**Purpose**
P.A. 91-80	Amended hospital budget review process by requiring CHHC to establish a "budgeted net expense cap" for each hospital for each fiscal year. To be exempt from budget review required hospital's projected expenses not exceed the budgeted net expense cap. Budgeted net expense cap is determined by adding the inflation plus 2% factor to the hospital's budgeted annual average net expenses.
P.A. 91-201	Made changes to and clarified provisions within the CT Small Employers Health Reinsurance Pool.
P.A. 91-258	Established a 16-member task force to study hospital rate discounts to health maintenance organizations (HMOs) and their effect on the cost and provision of health care in the state. Act also required HMOs to file copies of discount agreements with CHHC.
P.A. 91-301	Established licensing requirements, minimum standards, appeal and enforcement procedures and civil sanctions for companies engaged in Utilization Review.
P.A. 91-2, Nov. SS	Established uncompensated care pool funded by assessments on all nongovernment payments to hospitals. The pool used to pay for the approved uncompensated care costs of hospitals; for underpayments to hospitals by Medicare, Medicaid, and CHAMPUS; and for the costs and obligations resulting from the pool.
P.A. 91-8, June SS	Act states that CHHC may not approve most requests for additional nursing home beds or modify the capital cost or expiration date of any approvals between 9/4/91 and 6/30/93 except for applications deemed complete as of 8/9/91. The moratorium does not apply to certain nursing homes requesting one-time CON for 10 additional beds provided the capital costs do not exceed $40,000 per bed.
P.A. 92-125	Amended law concerning health insurance for small groups by providing for renewability of coverage if small employer carrier discontinues a product line; allows for reenrollment under certain conditions when coverage was rescinded for fraud; limits the range in rates offered or charged for a rating period; reduces the maximum allowable percentage increase in rates; provides that differences in premiums for plans be based on differences in plan design and not on the nature of the plan selecting the plan.
P.A. 92-220	Extended the deadline on moratorium on CON for new nursing home beds and modifications to existing ones from 6/30/93 to 6/30/94. The act also sets deadlines for construction to begin for projects under existing CONs.
P.A. 92-16, May SS	Contingent upon OPM and CHHC decision that this act is required under federal law: provides that beginning October 1, 1992 the pool will no longer pay for underpayments to hospitals by government payers (Medicare, Medicaid, and federal Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). Permits the pool to pay for the costs of the pilot program of health insurance for unemployed people created by this act; the state subsidized nongroup children's insurance pilot project established under PA 90-134 and amended by P.A. 91-11 June Special Session; and other research and demonstration projects authorized by P.A. 91-2, November Special Session.

Appendix A. Major Legislation Affecting Commission on Hospitals and Health Care (CHHC).

Public Act No.	Purpose
P.A. 93-44	The act: • subjected all short-term general hospital charges for patient care services (except government patients) to the state's 6 percent sales tax and requires all funds collected from the tax to be paid to the state's uncompensated care pool; • increased pool assessment to 12.6 percent beginning with FFY 94; • requires OPM secretary to determine and notify CHHC of the maximum amount of disproportionate share payments eligible for federal matching funds under Medicaid -- from that, CHHC must determine how much of the government underpayments to hospitals can be paid from the pool. Establishes a formula to determine the proportion of government underpayments. • Changed budget review formula.
P.A. 93-229	The act: • changed CCHC hospital budget review system for fiscal year 1994, granting hospitals a 4.24 percent increase in gross revenue and 3.25 percent in net revenue per equivalent discharge and provides for possible adjustments to these levels; • forgives hospital FY 90 compliance adjustments not previously assessed and will forgive FY 92 hospital compliance so that no hospital receives less than its previous year's authorized revenue for FY 94; • requires applicants for a CON to submit a letter of intent prior to submitting an application. • requires hospitals to file their discount agreements with CHHC. • changes funding for CHHC by assessing hospitals for the costs of CHHC operation, rather than CHHC being funded by the general fund.
P.A. 93-262	Transferred CON approval for long-term care facilities from CHHC to the Department of Social Services.
P.A. 93-345	Required small employer health insurance carriers to use adjusted community rating in establishing premium rates in plans issued after June 30,1995. The act also prohibits small employer carriers from denying coverage to small employers because of claims experience or health status.
P.A. 93-358	Established filing and notice requirements for preferred provider networks operating or seeking to operate in the state with CHHC.
P.A. 93-381	Required Department of Public Health and Addiction Services to develop a multi-year comprehensive state health plan. Required CHHC to given a written explanation whenever granting, modifying, or denying a CON that is inconsistent with the state health plan.
P.A. 93-406	Limited the addition of new nursing home beds by providing that all CONs for new beds which were not yet constructed by June 9, 1993 expire.
Source: Summary of Public Acts, Office of Legislative Research	

Appendix B: A Selected Profile of Other State Health Care Reform

Rather then await action by the federal government, several states have launched their own health care reform initiatives. In introducing reform measures, state efforts have concentrated on achieving the following three goals: containing health care costs, ensuring quality in the delivery system, and increasing access to services. The public debate surrounding these goals has focused on:

- scope of coverage;
- scope of benefits;
- cost containment strategies;
- financing access and other reform efforts; and
- ensuring quality care in the delivery system.

Although the goals of reform are uniform, states have demonstrated remarkable diversity in the legislation proposed to implement these goals, particularly in the area of access to health care. Some states have sought to quickly provide universal access to health care and define a minimum set of benefits, while other states have favored an incremental approach. Furthermore, there has been a variety of organizational structures, financing schemes, and delivery strategies that states have devised in order to design programs that meet the needs of their own populations. Measures to contain costs have been more uniform across the states including establishment of managed care programs, determining global budget targets, and developing practice guidelines and data collection mechanisms to encourage the appropriate use and distribution of services.

Although almost all of the 50 states have proposed legislation and enacted some type of health care reforms, there are a few states that serve as potential models. These include Florida, Hawaii, Maryland, Minnesota, Oregon, Vermont, and Washington. A brief profile of these states is presented below.

FLORIDA. In 1993, Florida approved the Health Care and Insurance Reform Act of 1993, which implemented major changes enacted the prior year (Health Care Reform Act of 1992). Together, these acts use a managed competition model as the basis for health care reform. The law is based on a voluntary, market-based approach that allows individuals, businesses, and government to pool their purchasing power to buy insurance. The law created two types of entities: 11 regional community health purchasing alliances (CHPAs) responsible for coordinating both the purchase and delivery of health care around the state, and a centralized Agency for Health Care Administration (ACHA) responsible for all health care regulation, financing, purchasing, and planning. The agency must develop state practice parameters designed to provide the most effective care and update the practice parameters every three years.

Membership in a CHPA is strictly voluntary and open only to small employers (25 employees or less), state employees and their dependents, and Medicaid recipients. CHPAs themselves may not provide insurance, directly contract with a provider, or bear any risks. CHPAs are specifically responsible for regulating the membership and the benefits offered by accountable health plans, and providing members with information so that comparisons between plans can be made.

The act also created a state program that provides access to health care for low-income individuals who are not eligible for Medicaid. Insurance reform measures included requiring guaranteed issue of benefit plans to small employers and application of a modified community rating standard to small employer.

HAWAII. Hawaii is the only state that has mandated, employment-based health insurance for all working residents. Since 1974, Hawaii has required most employers to provide health care coverage to employees that work more than 20 hours a week. Employers are required to contribute at least half the cost of employee coverage, and an employee's contribution cannot be greater than 1.5 percent of his or her monthly wages.

In 1989, Hawaii passed the State Health Insurance Program (SHIP) enacted to encourage the purchase of qualified health benefit plans by uninsured individuals who are below 300 percent of the poverty level, by providing a subsidy. Coverage under this program is provided for those not insured through an employer, eligible for Medicaid, or able to purchase private insurance.

In recent years, Hawaii has experienced significant increases in health care costs. In response, a Blue Ribbon Panel was created in 1990 to study the implementation of a system of managed competition for publicly funded coverage.

MARYLAND. Historically, Maryland has had a strongly regulated the health care industry. In 1976, an all-payer hospital rate setting system was established. All payers of health care bills -- the government, private insurers, or individuals -- pay the same government-set rates for the same medical service.

In 1993, legislation that focused on increasing access through insurance reform and containing health care costs, was passed. The law required insurance carriers to offer group health plans with a standard benefits package to small employers; provided for regulation of physician (and other provider) fees; and provided for systematic information gathering on procedures, fees, and payments. Rates for certain health insurance premiums and medical services will also be limited.

The legislation requires insurers to offer a comprehensive standard benefit plan to all employers with 2 through 50 employees who work a minimum of 30 hours per week with premiums based upon community rating.

MINNESOTA. The Minnesota Health Right Act of 1992 had two objectives: to provide universal access and to contain health care costs. The act included provisions for setting overall health care spending targets, monitoring providers, reviewing the distribution of new health care technologies, and evaluating methods for collecting health care data. The goal of the cost containment effort is to reduce the rate of growth in health care spending by at least 10 percent per year over a five year period. Health insurance reform measures included eliminating or restricting certain underwriting practices, and authorized the establishment of a statewide reinsurance pool.

In 1993, the MinnesotaCare Act was passed that mandated the formation of integrated service networks and, for those services not covered by a network, mandated an all payer reimbursement physician system. The annual growth limits on health care expenditure were established, as required under the 1992 act. All health insurance companies, HMOs, and other health plans were mandated to keep their expenditure and revenues within those limits. Other aspects of the legislation dealt with the collection and compilation of information on costs and quality for distribution to the public.

OREGON. The Oregon Health Plan seeks to provide universal access to health care for low-income citizens not eligible for Medicaid by prioritizing health care services and determining which will be covered by the basic benefit package. An ongoing Health Services Commission is charged with modifying and updating the prioritized list of health care services. In March 1993, The Department of Health and Human Services (HHS) approved the benefits package as it now stands. However, any change in the services covered would require further HHS approval.

VERMONT. The Vermont legislature established a Health Care Authority. Staff and resources from the state's health planning agency, its hospital budget and data functions, and its certificate of need (CON) program were merged into the new Health Care Authority. The authority was given the responsibility of developing two separate proposals:

- single-payer proposal; and
- multi-payer proposal.

Each of the proposals, which must be submitted to the Vermont legislature in November 1993, must provide for universal access to health care, use global budgets for expenditures, and have an overall statewide plan for the allocation of resources. The authority will also develop a unified health care database incorporating data on health care expenditures and the utilization of services.

WASHINGTON. In 1993, the state enacted the Washington Health Services Act. The main features of the act included:

- universal access by July 1, 1999;
- uniform benefits package by 1995;
- cost control mechanisms;
  - maximum community-rated premium cap,
  - managed competition among certified health plans, and
  - health services be provided through managed care systems

The act required all employers to pay at least half of the costs of health care insurance for employees and their dependents by July 1999. Low-income and unemployed individuals would be covered under the existing state subsidized health plan.

The act anticipated creation of four regional health insurance purchasing cooperatives (HIPCs) throughout the state. HIPCs will be required to admit all individuals, employers, and groups and make available to members every health care program offered by every certified health plan operating within the cooperative's region. All elements of the uniform benefit package must be offered as certified health plans by July 1, 1995. The legislation also provides for increasing the enrollment in the Washington Basic Health Plan (state-operated medical assistance program for low-income individuals ineligible for Medicaid) and Medicaid. Financing expanded access will be through various taxes, including "sin" taxes. The legislation also called for the creation of a statewide health data system that includes information on cost, quality, and outcome of health services. The state health department would be required to develop reports based on this information for consumers.